O&G
Magazine
Vol 17 No 3 Spring 2015

Women at work

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists

O&G Magazine

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ISSN 1442-5319

Cover: © Tim Westhaven

Women at Work

Women's health

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From the President

Prof Michael Permezel
President

The College was very pleased to welcome Ms Alana Killen as the new CEO of RANZCOG. Alana started with the College on 29 June 2015, after four years as CEO of the Australasian College for Emergency Medicine (ACEM). RANZCOG is indebted to the College staff who performed exceptionally well during the months following the departure of the previous CEO.

ANZOGSS

Prof Ian Symonds hosted the inaugural meeting of the Australian and New Zealand O&G Students' Society (ANZOGSS) at the College in July. This is an initiative to provide increased connection between the College and those students interested in pursuing a career in our specialty. While we have no shortage of applicants to enter the FRANZCOG Training Program, it is hoped that ANZOGSS will facilitate pathways for students; fostering their interest in women's health with a view to a long-term career in the most rewarding of all disciplines.

FIGO

RANZCOG was very pleased to be the host society for the meetings of the FIGO Executive in Melbourne in May. As part of these meetings, the College was pleased to offer delegates site visits to leading tertiary hospitals in Melbourne as well as to deliver an educational seminar on topical issues facing our specialty in this region. Following discussion at the meeting of the FIGO Executive, FIGO President, Prof Sir Sabaratnam Arulkumaran, advised the College that Sydney is the recommended venue site of the 2021 Congress. That recommendation will be considered by the full FIGO General Assembly at the 2015 FIGO Congress in Vancouver; however, we will come up against significant competition from other bidding cities in the Asia-Oceania region.

Education and Training

Procedural training numbers

Some very good work by College staff has resulted in a report of procedural numbers undertaken by our Trainees at the various training hospitals. As indicated many times previously, the College plans to place Trainees at those sites where procedural training is likely to be better and reduce Trainee numbers at the sites with lesser procedure numbers available to Trainees. Immediate and dramatic reductions in Trainee numbers at hospitals struggling to provide procedural training will cause significant staffing problems;

the College will work constructively with these hospitals to assist them with staffing models that can provide an efficient clinical service with a compliment of Trainees for which they are able to provide adequate training. For example, reducing the employment of specialist international medical graduates (SIMGs) may increase procedural training availability for local Trainees.

Discrimination, bullying and sexual harassment

The Royal Australasian College of Surgeons (RACS) continues to explore strategies to reduce discrimination, bullying and sexual harassment in the workplace. RANZCOG has made a detailed submission to the RACS Expert Advisory Group on the prevention of discrimination, bullying or sexual harassment. Our College has zero tolerance for these behaviours, but recognises that effective elimination requires the employing hospitals to accept their pivotal role in the detection and investigation of inappropriate behaviour and enforcing sanctions where retraining has not been effective.

Women's Health

FSEP and PROMPT

The Fetal Surveillance Education Program (FSEP) had been widely acclaimed for providing multi-disciplinary training in this crucial area of women's health. On-site training in obstetric procedures is another area where the College believes it can contribute to effective multi-disciplinary training to the benefit of women and their babies. Fellows have invested considerable resources into adapting the PROMPT (PRactical Obstetric Multi-Professional Training) program for Australia and New Zealand and delivering the courses. RANZCOG is currently negotiating with the PROMPT Maternity Foundation (UK) to enable the College to continue to deliver PROMPT training courses throughout Australia and New Zealand. Regardless of the outcome, multidisciplinary onsite obstetric procedural training will remain an important area of College activity.

Rh(D) Immunoglobulin

CSL Behring recently updated the Rh(D) Immunoglobulin-VF product information with respect to women with a body mass index greater than 30. The Australian Red Cross Blood Service and the National Blood Authority convened an expert panel to make some pragmatic recommendations. The Working Party's Position Statement and the FAQ Paper have been endorsed by the RANZCOG Board and can be accessed on the College website. Substantive changes to current practices have not been recommended.

National Cervical Screening Program

The renewed National Cervical Screening Program (NCSP; Australia) is expected to commence in 2017. It is extremely likely that the Federal Government will mandate quality assurance (QA) in colposcopy as it does for the other elements of the NCSP. Government representatives met with me and the Chair of the CPD Committee, Dr Vijay Roach, in June. RANZCOG advocated

for QA programs to be as user friendly as possible and had some suggestions in this respect. The College is also strongly of the view that equity of access and continuity of provider are important elements of quality of service – alongside the more technical aspects of the procedure itself.

Medical Benefit Schedule revisions

The Federal government has flagged a major review of the Medical Benefits Schedule under the chairmanship of Prof Bruce Robinson. While government has determined that neither the Australian Medical Association nor the specialist medical colleges will be represented in the review, RANZCOG is hopeful that there will be significant representation of RANZCOG Fellows on the relevant committees to maximise the likelihood that recommendations will achieve the stated objective of improved patient care.

College Statements and Guidelines

All Trainees and Fellows are encouraged to visit the Women's Health section of the College website where they will find the collection of statements and guidelines to be an invaluable resource. In addition to our own College statements, there are now many links to outside resources – both endorsed and other documents that are regarded as useful at a level less than endorsement.

Patient information

Some imaginative and extensive *pro bono* work by RANZCOG and Australian and New Zealand College of Anaesthetists Fellows has resulted in the development of quality animated videos on both caesarean section and epidural anaesthesia that are now hosted in the Women's Health section of the College website. These are openly available at no cost. Fellows interested in promoting these videos to their patients will find links to the animated videos along with links to written patient information on the page: www.ranzcog.edu.au/womens-health/online-patient-information.htm .

Asia Pacific and Global Women's Health

At the recent meeting in Fiji, Prof Alec Ekeroma stepped down after an outstanding term as President of the Pacific Society of Reproductive Health (PSRH). Alec's dedication to improving women's healthcare in the Pacific Island Countries has been truly remarkable. RANZCOG congratulates Ms Kathy Gapirongo from the Solomon Islands as the incoming PSRH President.

Selection

At the time of writing this report, the FRANZCOG training selection process for Australia is in process, with the interviews scheduled for 7 August 2015. Applications far exceed the number of available positions, with more than 250 eligible applications for approximately 80 positions. This year, approximately two-thirds of applicants will be interviewed. The College will strive to develop refinements to the selection processes to result in the best future Trainees being selected. Key to determining the best selection strategy will be feedback from hospitals on how those selected perform as Trainees. This will enable the College in the future to reflect back on those selection strategies that lead to higher selection scores from the better performing Trainees.

From the CEO

Alana Killen
CEO

Having commenced at RANZCOG on the 29th June, the past few weeks have been spent becoming familiar with RANZCOG systems and processes, meeting staff, attending meetings and developing an understanding of the College's philosophy, vision and strategic objectives.

For the past six years I was employed at another specialist medical college, the Australasian College for Emergency Medicine (ACEM), initially as the Director of Education and then as CEO. It is interesting to gain an insight into the similarities and points of difference and those things that make RANZCOG unique. I have been welcomed warmly by the staff, Board and Council and impressed by the level of commitment and enthusiasm demonstrated by those who volunteer their time by serving on the various committees and working groups.

Before beginning my role, I was made aware of the College's strategic plan for the coming three years. Not surprisingly, education is a key objective, with online learning and technology featuring highly on the list of planned initiatives. Aligned with this is the desire of the College to engage more meaningfully with its members; to add value to their professional lives and provide enhanced opportunities for participation and interaction.

> 'One of the major challenges facing a federated organisation, such as RANZCOG, is the ongoing exchange of information and how this can best be facilitated.'

Over the past few weeks, I have been fortunate to have attended several regional committee meetings, and hope to attend all regional meetings over the next few months. This has enabled me to learn more about the local matters affecting our Fellows and

Trainees as well as the specific medico-political issues relating to the regions. One of the major challenges facing a federated organisation, such as RANZCOG, is the ongoing exchange of information and how this can best be facilitated. Effective communication is a challenge for any business, group or society, no matter how large or small, and it is my hope that we can continue to build on and enhance our ability to communicate effectively with our members and Trainees as well as with the broader community.

The College website is often the first point of contact for those wishing to learn more about RANZCOG and its activities and so in the coming months, our focus will be on evaluating the current site; from both an external and internal perspective. We hope to make the website more user-friendly as well as more informative and interactive and would welcome your feedback and suggestions as to how this might be achieved.

It is always a challenge to meet the needs of a diverse group of people, who may have different values and expectations. One of the critical factors is maintaining and respecting those aspects of the College that are important to the membership (such as its history and traditions) while striving to be a contemporary and relevant organisation. I am looking forward to meeting the members of the College and learning more about how they view these often conflicting and sometimes complementary aspirations. I am also looking forward to assisting the College build on the excellent reputation it has earned over many years and hope my contribution may, in some small way, support the continuation of this evolution.

Editorial: adjusting the balance – women at work

A/Prof Stephen Robson
FRANZCOG

In Sex at Dawn[1], psychiatrist Cacilda Jethá and her husband Chris Ryan quote Steven Goldberg – for many years Chair of Sociology at the City College of New York[2]:

> Patriarchy is universal […] There is not, nor has there ever been, any society that even remotely failed to associate authority and leadership in suprafamilial areas with the male. There are no borderline cases.

Jethá and Ryan quickly proceed to pick holes in Goldberg's statement, quoting anthropologist Peggy Reeves Sanday.[3] Prof Sanday spent many years living with the Minangkabau peoples in the highlands of Sumatra. The Minangkabau are noted for their strong interest in education and the Minang diaspora have become successful reforming politicians, journalists, writers and business people. The Minangkabau are also a true matriarchal society. Prof Sanday points out: 'Males and females relate more like partners for the common good than like competitors ruled by egocentric self-interest…[and] women's prestige increases with age and accrues to those who promote good relations.'

I have to say matriarchal societies sound great, if this description is anything to go by. Jethá and Ryan note: 'Societies in which women have lots of autonomy and authority tend to be decidedly male-friendly, relaxed, and tolerant…[and] tend to be far more comfortable places for most men than societies ruled by a male elite.'

The great majority of our Trainees are women and if the above anthropological observations provide any guidance, perhaps a golden age may be upon us. Certainly, the era of ageing male specialists working in grinding solo practice – something I've been doing for many years – will become a memory. Surveys tell us that women are likely to work smarter than ailing dinosaurs like me. You will note that I have studiously avoided the phrase 'feminisation of the workforce'. As Brisbane-based emergency physician Dr Alex Markwell has written:

> There is one phrase that makes me cringe more than any other: 'the feminisation of the medical workforce'. Why do we use a term that describes the development of secondary female sex characteristics to describe the increased proportion of women in the medical workforce? Surely a better term is one that doesn't evoke a shudder or fear: the 'normalisation' of the medical workforce.
>
> Does this represent a hostile invasion of medicine by women? Hardly…Monash University social scientist Dr Jo Wainer describes the different intrinsic knowledge that women and men have. Women bring intuition, empathy and instinct – all valued skills in medicine. Of course these characteristics can be learnt by men, but they need role models and these qualities must be valued.[4]

According to Auckland-based general physician Phillippa Poole[5]:

> The feminisation of the medical workforce should be a solution, not a problem… Most women will have children and this will overlap with the training years. Flexible workplaces and good career re-entry will keep women in the workforce. Women also need support to lead because they are under-represented in national medical leadership and academia. Research has shown more doctors will be required to make up for the fact women work fewer hours, and there will be fewer people willing to work rurally.

Recent recipient of the RANZCOG Presidential Medal, Prof Caroline de Costa, pointed out in her acceptance speech there aren't too many female names on the College Honour Boards. That's true, but it is something that will surely change soon. In this issue of *O&G Magazine*, our team has put together stories of women at work. My own special interest is the health and wellbeing of women at disadvantage and you will find stories about migrant women and from women working in the Pacific.

Spring is the season of growth and renewal and we can't think of a better time to celebrate the achievements, and to examine the challenges, of women at work. As always, a big thank you to all of our contributors. If you have any stories or comments, the team at *O&G Magazine* would very much like to hear from you. In the meantime, I'll let you ponder something more from Jethá and Ryan[1]:

> Maybe matriarchal societies are so difficult for Western male anthropologists to recognise because they expect a culture where men are suffering under the high heels of women… Instead, observing a society where most of the men are lounging about relaxed and happy, they conclude they found yet another patriarchy, thereby missing the point entirely.

Happy reading!

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Recognising the women in women's health

A/Prof Stephen Robson
FRANZCOG
Vice-President (Women's Health)
RANZCOG

It isn't often that your career choice is given the once-over during 'ovaries week' in *New York* magazine. In September last year, writer Alyssa Shelasky published the following[1]:

> The male gynecologist can be a polarizing figure: Some women avoid them as a personal policy, while others actively seek them out. Regardless of your stance, though, they're becoming a rare breed. Nationally, 80 per cent to 90 per cent of people graduating in OB/GYN are women; and at NYU School of Medicine, approximately one out of seven OB/GYN residents are male. But what motivates those who do choose this female-dominated – and female-focused – field?

The gender balance of Trainees and younger specialists in obstetrics and gynaecology has so drastically changed that males in the field are officially now being referred to as 'a rare breed.' As if *New York* magazine doesn't have a large enough readership, Shelasky's online article was syndicated by websites such as Jezebel, with a readership in the tens of millions, and it attracted hundreds of comments.

Only a few years before websites such as Jezebel took issue with male gynaecologists, John Queenan, the esteemed editor of *Obstetrics and Gynecology*, tackled this issue head on in an editorial he titled, Making career choices – women and men in obstetrics and gynecology.[2] Queenan began:

> Over the past few decades, women have increasingly chosen to enter the once male-dominated specialty of obstetrics and gynecology. Consequently, investigators have studied and speculated on the effect of gender on productivity and compensation in the specialty. However, in many studies comparing women with men in the professional work force, authors seem to be walking on egg shells, fearing the risk of making politically unpopular statements.
> During these decades, an evolution has occurred in the practice of obstetrics and gynecology. Our profession has moved away from the solo practitioner model as many opportunities have opened up providing choices in the style of practice (eg, partnerships, multi-specialty groups, and hospital-based and HMO-based practices).

The editorial accompanied a paper written by an economist specialising in health, Prof Jessica Reyes of Amherst College in the US.[3] Over 12 years, from 1991 until 2003, she surveyed Fellows of the American Congress of Obstetrics and Gynecology (ACOG), reporting that female specialists were 'less productive in terms of hours worked, patients seen, and procedures performed.'

Prof Reyes found that this 'decreased productivity' meant women in the specialty earned less, but worked fewer hours and were more likely to be in a salaried position than in private practice. This led her to comment:

> This is the most striking conclusion of the present analysis: according to the most recent available data, male and female obstetrician–gynecologists who practice in the same manner appear to receive the same incomes. Gender does not matter. It is only when female obstetrician–gynecologists choose less financially rewarding practice arrangements or do less (see fewer patients, work fewer hours, perform fewer procedures) that they earn lower incomes.

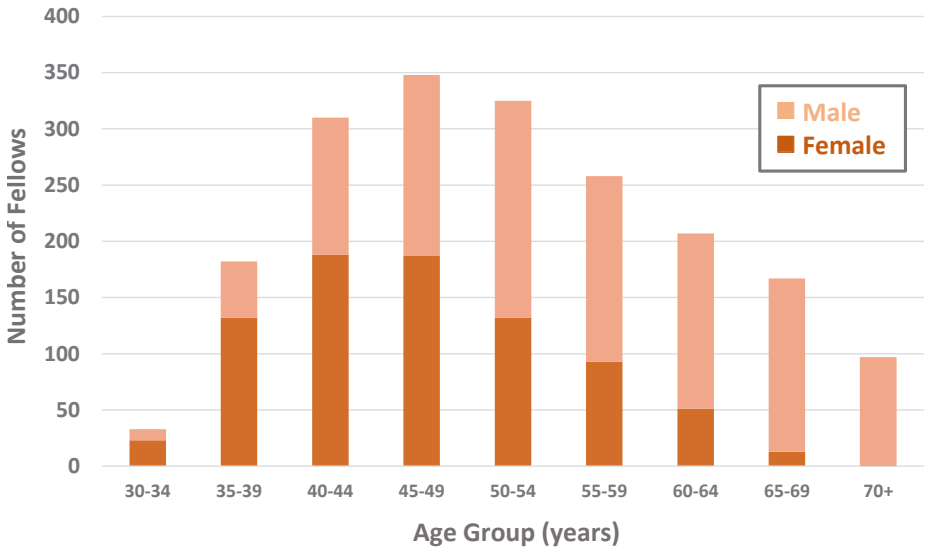

Figure 1. Gender distribution of RANZCOG Fellows in 2014.

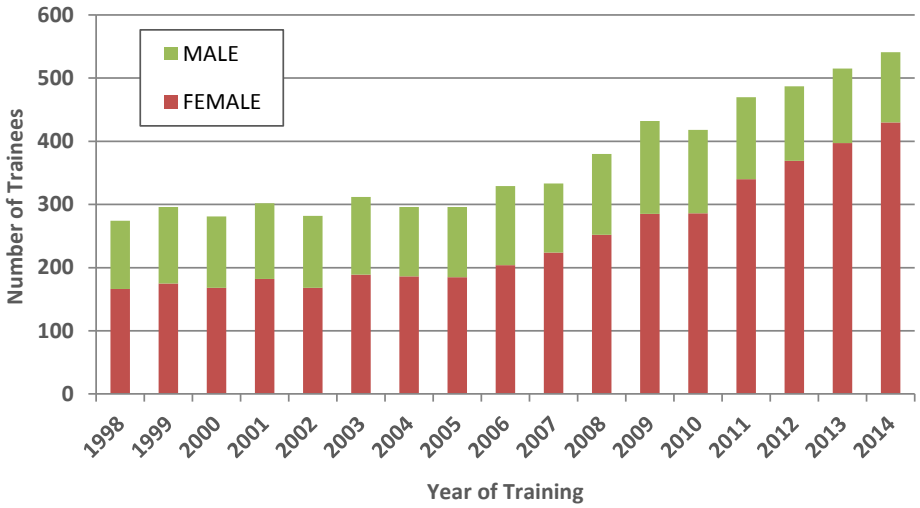

Figure 2. Proportion of female and male RANZCOG Trainees in Australia, 1998–2014.

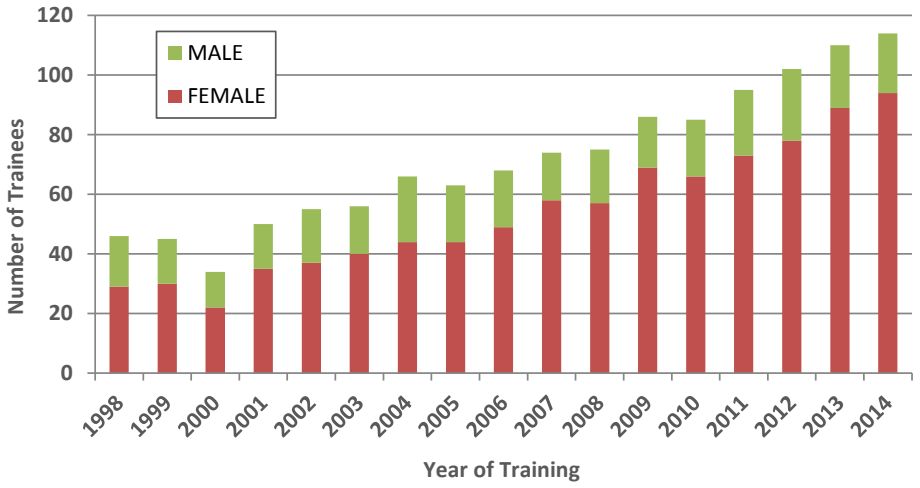

Figure 3. Proportion of female and male RANZCOG Trainees in New Zealand, 1998–2014.

Queenan[2] noted that of recently qualified specialists who were Fellows of ACOG, 73 per cent were women. This proportion is very similar to that in Australia and New Zealand. In 2014, 69 per cent of final year speciality Trainees were female and in the same year almost 80 per cent of applicants for specialty training were women. In the workforce survey of last year, 43 per cent of all Fellows of the College were women, so as new Trainees move into the specialist workforce there will be a reversal of the gender balance. There is already a dramatic change in the proportion of women in the workforce in younger age groups (see Figure 1). The proportion of women in training has dramatically increased over the last 15 years, as can be seen in data from Australia (see Figure 2) and New Zealand (see Figure 3). A similar change in gender distribution is apparent in RANZCOG Diplomates, with 59 per cent of all Diploma-holders female in 2014, but an inverse ratio in older age groups (see Figure 4).

Health Workforce Australia noted that the specialties with the greatest proportion of women were paediatrics and obstetrics and gynaecology, as well as psychiatry, anaesthetics and medical imaging. The specialty groups with the lowest proportions of women were all surgical, with less than five per cent in cardiothoracic surgery. This was attributed to the length and structure of the various specialty training programs, 'family considerations' and 'work considerations' – hours worked and participation in on-call rosters.[4]

In a RANZCOG submission to the Australian Productivity Commission written in 2005, and based on workforce surveys, it was noted, 'female Fellows work about ten per cent fewer hours per week than male Fellows.' A more recent analysis, commissioned by the Royal College of Obstetricians and Gynaecologists (RCOG) and published in 2012[5], made the following points:

> The full implications of what will soon be a female-dominated medical workforce are still not understood. Much will depend on future behaviour, which is far from entirely predictable. But it is more than likely that many women will take at least some time off work when they have families, and many may wish to work less than full time for part of their career. Furthermore there is appreciable evidence that men entering medicine now want the same opportunities for a more generous work-life balance and may be less committed to full-time working than their forebears.

> 'The era of male-domination of obstetrics and gynaecology is at an end…the new generation of both specialists and Diplomates will be largely female.'

A study examining trends in obstetrics and gynaecology workloads in Canada[6] reported that:

> Female physicians were more likely than male physicians to relinquish obstetrics, particularly in the prime years in the middle of their career. Furthermore, as an increasing proportion of obstetrician–gynecologists withdraw from obstetrics, the obstetrical workload increases for those obstetrician–gynecologists who continue to do obstetrics, especially if they are male. The lower participation in obstetrics by women is congruent with past research showing that female physicians work fewer hours than men. The reasons for this finding deserve further research. One obvious possibility is that concerns about balance between work and family life may encourage

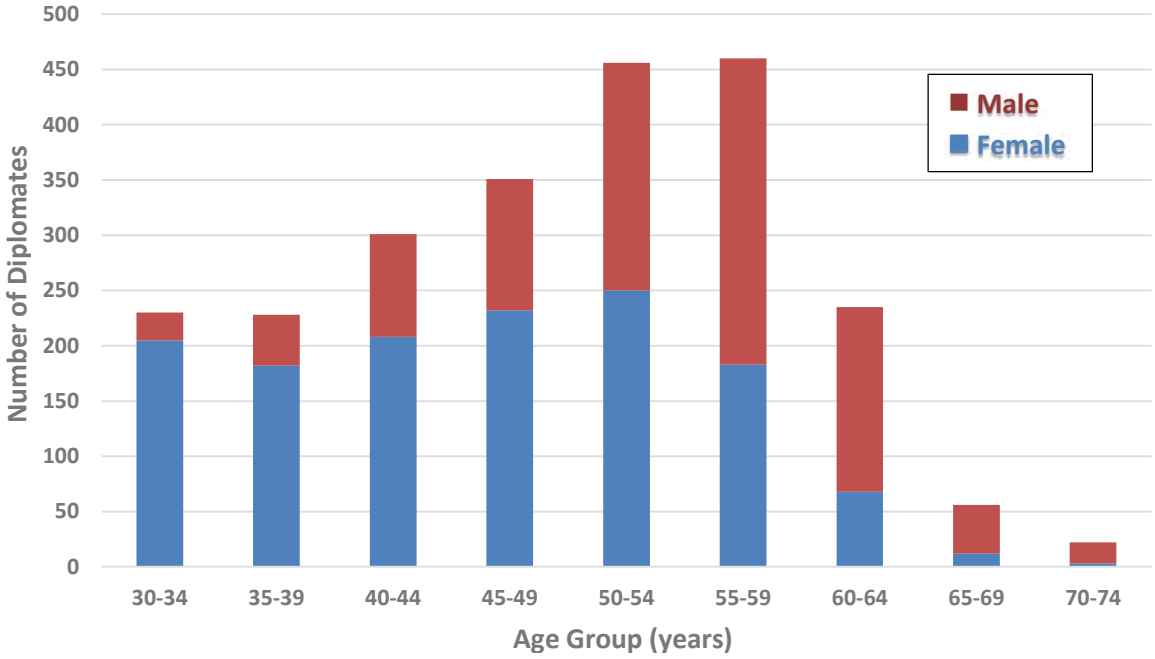

Figure 4. Gender distribution of DRANZCOG holders in 2014.

> women to relinquish obstetrics more readily than men.

Whether this effect holds in Australia, a country very similar to Canada, remains unclear. What is clear is that pooled data suggest that female specialists might be more popular with women because of their style. A systematic review of studies[7] concluded that:

> Most patients preferred a female rather than a male gynecologist–obstetrician. This was partly explained by a more patient-centered communication style used by female gynecologists–obstetricians. Also experience and clinical competence were important factors in choosing a gynecologist–obstetrician. It was not clear whether patient's age or ethnicity influenced patient gender preference. Patient satisfaction increased when gynecologists–obstetricians used a patient-centered communication style.

Where does this leave men? It seems that the dwindling proportion of men who are choosing obstetrics and gynaecology as a specialty are doing it for reasons even Jezebel approved of[1]: 'It might sound strange coming from a doctor, but I'm kind of freaked out by sickness and death. Becoming an OB/GYN translated into life and family and the beauty of humanity for me. There's so much hope in my office, not much doom and gloom!'

In an article posted a couple of years earlier, Jezebel asked the question: do men make better gynaecologists?[8]

> Perhaps the most interesting finding in… studies of gender in the patient-doctor relationship involves male doctors who practice obstetrics and gynecology… This group of male physicians has been shown to be significantly better than their female colleagues at showing empathy and talking to patients about their emotional concerns…

Where does that leave us? The era of male-domination of obstetrics and gynaecology is at an end and, with older specialists leaving the workplace, the new generation of both specialists and Diplomates will be largely female. Studies tell us that women tend to work slightly less and demand more flexibility in their work arrangements. In the strict economic sense, female specialists are less productive, but patients naturally respond to a patient-centred style of practice. Workplace productivity can make it trickier for planners to get their numbers right.

However, the outlook is anything but gloomy for men entering specialty training in women's health. Those who wish to pursue such a career tend to have the qualities that patients look for and obviously have the opportunity to work in a field that has captivated people for many years. Who could wish for anything more?

Acknowledgements

Many thanks to Effie Margiolis and Lyn Johnson for assistance in obtaining data for this article.

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Lyrical reflections on a working life

Dr Sue Fleming
MBChB, FRANZCOG, EMBA

In 1973, when I graduated as one of eight women in the first group of medical students from the new University of Auckland School of Medicine, I was filled with optimism about my professional future. I was largely unaware of any barriers I might meet professionally because I was a woman. Perhaps this was because as a first graduating class we received special attention from our teachers or perhaps because it was the general optimism of the time. For me, this optimism was best captured by the Pointer Sisters' hit song 'Yes We Can', and its lyrics that focused on building a better world through hard work and kindness.

I moved to Australia immediately after graduation. In the early 1970s, women made up only 13 per cent of medical practitioners and were strikingly under-represented in our specialty. In Sydney, where I undertook my training, there were only a handful of female specialists and no women in training positions. Despite obstetrics and gynaecology being a popular specialty with female students, the training environment, demands of specialty practice and lack of role models discouraged women from entering the specialty. Trainees commonly worked a 24 hours on duty one-in-four roster during the week in addition to daytime duties and 48 hours on duty at weekends. Maternity leave was available, but not 'encouraged'. My entry interview into the specialty included direct questioning of my contraceptive practice. The majority of specialists after completing training worked in solo private practice, with honorary hospital appointments. Securing a position at one of the larger academic hospitals generally required a Trainee to have completed a period of international training.

Increasing feminisation of medicine

In the 40 years since I commenced my specialist training, the proportion of women attending medical schools and choosing to specialise in obstetrics and gynaecology has steadily risen in Australia and New Zealand along with most developed counties. In 2010, the 13th Australian Medical Training Review Panel report for the Department of Health demonstrated one of the highest percentages of female basic trainees occurred in obstetrics and gynaecology (65 per cent), in comparison with the overall average (47 per cent) for other specialties.

Over the last four decades, substantial changes have occurred in the medical work and training environment. Long hours and largely unstructured training have been replaced with regulated work conditions (largely imposed by external agencies and a unionised workforce) and a modular, structured approach to training. These changes have encouraged more women to enter medicine, and with it our specialty, and have better enabled them to meet their professional and personal needs.

Changing medical professionalism

The progressive feminisation of the medical workforce has been mirrored by a significant change in what constitutes medical professionalism. This is defined by the Royal College of Physicians as the set of values, behaviours and relationships that underpin the trust the public has in doctors.[1] A review of the contemporary literature suggests medical professionalism has undergone significant change in five distinct dimensions: from physician autonomy to working collaboratively; from individual professional judgment to evidence-based care; from personal responsibility to public accountability for outcomes; from personal control to shared responsibility; and from doctor-led spending to shared responsibility for appropriate allocation of resources.

Is this change a consequence of the feminisation of the medical workforce? It is difficult to know for sure, however, what can be said is that women are perhaps more likely to naturally embody these principles of new medical professionalism. Women are typically more sensitive to patients' physical and emotional concerns and more likely than their male counterparts to engage patients as active partners in their care.[2] Female doctors may also be more inclined towards a team-based approach to care.[3,4]

Impact on status of medicine

It has been suggested that the increased feminisation of the medical workforce would result in a decline in the status of the profession. In Russia and Estonia, where women have long dominated medicine, the profession is considered a low-status occupation.[5,6] However, a decline in status does not appear to have occurred in the Western world. A Roy Morgan survey showed that the percentage of Australians who rate doctors as having high to very high ethics and honesty increased from 63 per cent in 1986 to 86 per cent in 2014. In the same year, United States data showed medical professionals to have the highest annual mean wages of all professional groups.[7] However, the income of doctors in the UK, US, Australia and New Zealand appears to be less for

female doctors than for male doctors.[8] The reasons for this are complex, but one factor is women are more likely to choose workplace flexibility and fewer on-call hours over a higher salary in order to preserve a work-life balance.

Impact on workforce productivity

There is some evidence that women engage in more patient centred communication and spend longer with patients. In the UK, NHS-employed, full-time female consultants see fewer patients than their male colleagues.[9] Interestingly, despite apparent differences in communication approaches and time spent with patients, studies do not consistently show higher patient satisfaction with female physicians.[10] While this information suggests that, as a group, women bring empathy and excellent communication skills to their patient contacts, this may be at the expense of productivity, something also valued in our resource-pressured healthcare environment.

How women's desire for more flexible work schedules translates into their contribution to the medical workforce over the course of their working lives is less clear. Reports from the 1990s and early 2000s showed women worked a shorter week and were likely to retire earlier than men.[11,12] In 2013, the AMA reported the median retirement age for obstetrician gynaecologists in the United States was 64 and women, on average, retired five years earlier than men.[13]

Lifestyle and career choices

The lifestyle challenges and issues that were traditionally the concern of women would now seem to be important to medical students and trainees both male and female.[14,15] Parenting physicians of both genders now actively seek to find a balance between their professional career and personal life, although the trend to working reduced hours is still more apparent with female physicians.[16,17] This trend is reflected across all work environments and is an inevitable consequence of the changing life values of our younger generations. As more doctors seek a work-life and work-family balance, we are becoming increasingly challenged to develop creative models for training and professional practice that will ensure well-trained specialists who have productive and satisfying professional lives.

At the end

As I draw closer to the end of my active professional life, it is gratifying to find women have gained a greater presence and stronger voice within our specialty. There is still a need for women to be more prominent in positions of influence and leadership. There is a tendency for change in medicine to occur with wide swings of the pendulum and then to settle to a more moderate position. The feminisation of our obstetrics and gynaecology workforce is an example of this. There is value in a diverse workforce united in a common purpose. Our specialty would be disadvantaged if we were to lose the skills and perspective that men bring to it. I trust the pendulum of change in this respect will find a sensible resting place.

It seems to me the workforce and training challenges we are facing in our specialty are not so much created by the feminisation of our workforce, but rather by the change in societal values. Once again, this is perhaps best summed by the music of the time, as Jon Bon Jovi so memorably declared: 'It's my life. It's now or never...I just want to live while I'm alive.'

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Specialist training while parenting: a juggling act

Dr Elizabeth Glanville
FRANZCOG Trainee

In recent years, more than 50 per cent of medical graduates in Australasia and 80 per cent of new obstetrics and gynaecology Trainees have been female. Therefore, RANZCOG has the opportunity to be a leading light in adapting training pathways to accommodate the changing characteristics of the medical workforce.

The stage of life of women when entering specialist training means, for many, the dilemma of how to fit training and having a family around each other is at the forefront of their minds. Some make the decision to complete their training before having children, but this decision may be easier for some compared to others. Many factors influence a Trainee's decision about the best time to start a family; including age, medical issues, fertility concerns, partner's career as well as the training pathway. As Trainees, we are often advised to focus on our career above all else to ensure progression to the perceived endpoint of becoming a specialist. However, this is a career of lifelong learning and as such there is no easy time to interrupt one's career to embark on another challenging job women can face: becoming a mother.

Before beginning my training in New Zealand, I had already spent several years in the RCOG training program in the UK. I relocated to New Zealand to get married and settle here. In order to continue my career, I had to take a backwards step, reapply to train and start again with the MRANZCOG exams. When I began a training position, it was not my intention to complete core training before starting a family; owing to my age and stage of life, I did not wish to risk my fertility to progress my career as I strongly believed it was possible to do both. Having seen many of my senior colleagues and role models combining training with having a family in the UK, I knew it was possible. At the time I started my first year of training in the RANZCOG program, I was expecting my first child.

Having a baby to care for was easily the most difficult job I have ever done. It was far harder than managing a labour ward or Women's Assessment Unit, with much longer hours and no breaks. Returning to work after 12 months of parental leave was daunting, but I felt I quickly settled back in and loved the balance of work and family life I had achieved. Having had the experiences of pregnancy, childbirth and caring for a baby, I felt empowered and believed I had a new level of understanding of the women I was working with. However, there were many challenges to come, including exams and moving in order to complete my rural placement. To have a family and fulfil the expectations of being a RANZCOG Trainee, I have found having a supportive partner absolutely essential. Childcare options are generally inflexible, expensive and not well tailored to the needs of medical families. There is constant guilt from feeling that you cannot give either of your two jobs 100 per cent of your attention. There is time spent studying when your child is wondering why you are hiding away and not willing to play. The question of how it is possible to do it all at once is a common one. The answer is with the support of family and friends, making small sacrifices and being both efficient with your time and self-disciplined. Having a partner who can share the responsibility – from taking care of the children while you study at home, to tending to the children when you're at work overnight – makes all these things possible.

After returning from parental leave, I worked full time because I wanted to reach the stage at which I could take my written MRANZCOG exam as soon as possible. I longed to spend days at home with my toddler and at times it was incredibly hard to leave her. I often questioned whether I was doing the right thing to continue pursuing a career in obstetrics and gynaecology. There seemed to be easier, more family-friendly options if I changed to career path, but I couldn't convince myself that I wanted to do anything else. This time was a true test of my commitment to the specialty, but I found being in this position strengthened my commitment to my career. I have seen many colleagues facing the same dilemma. More often than not, they seem to choose to continue obstetrics and gynaecology; a demonstration of what an exciting and wonderful career it is.

I had to move to Rotorua (two-and-a-half hours from home) to complete my rural placement and, because of this, my family was forced apart. My husband has a demanding job in the city and his work commitments meant that he had to remain in Auckland. Thanks to the understanding of his employers, he was able to take six weeks off work to come to Rotorua with our daughter during the middle part of my placement and I am very grateful to him for taking that time out for our family. Having that time together was our reward for spending the first third and last third of the placement apart. During this time I was also studying for the written MRANZCOG exam. Life was a blur of working, studying and traveling to and from Auckland to see my husband and 16-month-old daughter. Getting through that time was incredibly hard, not to mention expensive. Other Trainees have moved their entire family for the rural placement, including school-aged children, which is also an enormous undertaking and can be disruptive to family life. I think the rural requirement is possibly the most difficult logistical aspect of training with a family and having

completed this makes the rest seem more achievable and far less daunting.

In the past two years, the College has become more flexible in its approach to part-time training, which can be of benefit to Trainees with families, providing the positions are available in hospitals where Trainees are placed. It is the responsibility of the Trainee to make the arrangement to job share. In most cases a job share arrangement of 0.5 full-time equivalent (FTE) is the only option for less than full-time training. Obviously, this leads to a doubling in the overall length of time taken to train and begins to stretch the limitations imposed by the College on length of training time, particularly where maximum parental leave has also been taken during training. A more desirable position for many would be somewhere between 0.5 and 1.0 FTE to allow Trainees to spend time with their young children, but continue to progress through training at a reasonable pace.

Accepting that women are likely to request alterations in their training program as they progress, perhaps a co-ordinator within the College could have the role of placing Trainees into less than full-time roles as requested, thus enabling these natural variations with minimum inconvenience to the hospital or Trainee. It may also be helpful if the College could work with hospitals to look at ways standalone, part-time positions might be created to maximise opportunities for Trainees desiring part-time employment.

> '...the College has become more flexible in its approach to part-time training, which can be of benefit to Trainees with families...'

Childcare is in high demand and full-time positions in the most sought-after facilities in big cities are hard to come by. In addition, if a Trainee has a partner who also works long hours, it is often impossible to co-ordinate childcare drop-offs and pick-ups and still get to work on time. Leaving before the end of an over-running clinic or theatre list to pick up a child is not seen as collegial behaviour and leads to Trainees with young children missing out on learning opportunities. Onsite childcare facilities with flexible hours to accommodate the variations of a roster, owing to nights and long days, would be invaluable for many across all medical specialties, not just in obstetrics and gynaecology.

In the end, a Trainee may need to make career choices that fit with his or her wishes for family life. Not all sub-specialities are suited to those with a family, unless there is a particularly supportive family member available to care for the children or the option of employing a nanny. Even with these supports in place, some parents may find it undesirable to spend as much time away from their children. For others this may be the perfect way to 'have it all'. I think it is heartening that we all have the option to choose our own pathway through this adventure.

For the future specialists in obstetrics and gynaecology, our College needs to continue to provide excellent support for women embarking on these most formative years of our careers and family and, in return, will be rewarded with capable, contented and passionate obstetrics and gynaecology specialists.

Singing the praises of flexible work patterns

Dr Alexandra Miglic
FRANZCOG

Dr Kae Wong
FRANZCOG

Alexandra writes

I've just arrived home from a long lunch at one of the local wineries followed by a walk on the local beach and am now looking out the window at the cattle grazing peacefully on the green hills while sitting by the fire with my beautiful border collies. This is a rather typical day off from my part-time position at a nearby tertiary centre. My perception of success has certainly changed in the past year.

My current working lifestyle is not what I once thought it might be. I grew up in Melbourne and went on to university and clinical training at various hospitals around that city. During this time, I witnessed a strong change to favouring private group practice that seemed to allow a more balanced lifestyle and, it appeared, maybe having a family and a career in private practice might just be possible.

I was fortunate, before and during my training, to spend some time overseas in both developed and less-developed economies, seeing how things were done there. I had a brilliant year of training in Cork, Ireland, on the advice of one of my very wise bosses in the early years. I also had the chance to broaden my perspective with working trips to indigenous communities here and in Kenya and Mongolia. I did, however, continue on the path I had always imagined, training in Melbourne and striving to attain sound practice and professional relationships with a plan to eventually set up group practice and combine this with a part-time public appointment. I looked forward to embarking on the balanced lifestyle we hear about and yearn for during the busy training years.

I gained my Fellowship in February 2014, and commenced working in a part-time public post while pondering private practice. Life was ticking along and I loved the increased autonomy and quieter life after the very busy training years. Enter husband and an opportunity for him to run a winery in McLaren Vale. I resigned and moved interstate with no job. I started locuming at this point and it has been brilliant and enjoyable and I chose to keep doing it despite landing a part-time public post in the meantime.

Currently, my husband and I have established a farm in a beautiful part of the world, I have a part-time public post at a tertiary centre in town and I travel for locums, mainly through the Rural Obstetric and Anaesthetic Locum Scheme (ROALS), run by the College. The locums afford me the opportunity to experience new people, places and practices, while giving the amazing rural practitioners some time to breathe. I particularly enjoy working with Indigenous patients in various parts of the country – a passion I have always had and am thrilled to be tapping into again. It is truly the best of both worlds, combining travel and locuming with a public post.

> '...it is vital to take opportunities to work in different environments and systems and thus discover what works for you both personally and professionally.'

In the public post, I have been blessed with a wonderful boss who is supportive of the women at work and, importantly, having a public post keeps one accountable and up to date, while also allowing for development of fantastic professional relationships and friendships. In our spare time, my husband and I enjoy our working property, running cattle and striving for self-sustainability with our chooks and veggie patch. I am still pondering private practice and adding that to the mix. Life is sweet – it's relaxed, it's wholesome, it's diverse – and it's fun.

Upon reflection, I feel it is vital to take opportunities to work in different environments and systems and thus discover what works for you both personally and professionally. On my journey I have been blessed with fantastic bosses who have been wonderfully supportive and terrific mentors, particularly in my transition to consultant and again in my transition to my work-life balance as it is today; they have made my journey to a happy, successful, balanced lifestyle possible.

Kae writes

When the call came through to ask if I would write a short piece on flexible work patterns, I was in the middle of trying to rescue a pot of pasta from bursting into flames (Bridget Jones style). The follow-up email stated the intention of this issue of the magazine is to look at various women in their careers and how they may differ from the old stereotype; because they have different needs and requirements to the classical male obstetrician and gynaecologist of the past. My name was

picked out of the hat, I understand, because I have previously participated in the Rural Obstetric and Anaesthetic Locum Scheme (ROALS) and, therefore, have clearly availed myself of a flexible work pattern.

As I found myself agreeing, I was asked if I had a family. I knew exactly what was being asked, but could not find an accurate, concise reply. Of course I have a family, but what was meant was a partner and children, then no, I didn't. 'Oh well, you know, flexible working hours are so beneficial when you have to bring up a family,' came the reply. I very nearly said – but refrained, because I didn't want to sound *ornery* – but they are also very beneficial for people predisposed to an indolent lifestyle!

> 'No one ought to take on this work without intentionally wishing it and ordering one's life to suit is mandatory.'

I do not believe in the existence of a stereotype, really. If there is such an entity as the 'classical male specialist of the past', I have not encountered him. Instead, I have met quite a few male specialists of an almost bewildering range of personalities and characters. Dr X, who used to do on-calls at the busy tertiary hospital I trained at, was an award-winning baker at the local agricultural show and did not, I was told sternly by my senior registrar, tolerate any Trainee who could not do a good double-handed knot. Dr Y has an open, jolly countenance, lives in a contemporary, fancy city apartment, is closely involved with his family, loves travel and good food and is wonderfully generous in his teaching of registrars. Dr Z is a benign gossip, such that theatre lists with him always float past very quickly. He has continued to do gynaecology clinics long into the sunset – the caesarean section rate, when he was a young consultant, he says, was four per cent. Dr A has travelled the tropics working in busy hospitals, spent decades at tertiary institutions in Australia and maintains a keen academic interest.

I cannot see how all these men would have a uniform set of needs and requirements. Indeed, their career paths have varied, I suspect, because they have tailored them to their specific needs. I like to think that life ought to be tailored also to desire and not mere need. Happy is the person who finds a convergence of need and desire, of course, and if my own story demonstrates anything at all, I hope it shows that registrars can do what they need and want at the same time.

Flexible work patterns should be contemplated by all members of our speciality, men and women alike. Engaging with women and babies at the most critical times of their lives is – in my sentimental opinion – a privilege of the highest order. No one ought to take on this work without intentionally wishing it and ordering one's life to suit is mandatory. I would never want to be an obstetrician and gynaecologist living any sort of work pattern by default. A non-purposive lifestyle cannot be conducive to the sort of excellence we should be aiming for. Therefore, I will continue to arrange my days as best as I can, to match my needs and desires and hope this coincidentally may achieve some sort of advantage to society.

My route thus far has been this: I spent my first two years of training at a solid tertiary institution in Melbourne, having never worked in obstetrics (or gynaecology) before. My third year was in country Victoria, at two separate regional hospitals boasting incredibly supportive, lovely consultants. Then I took a year off training, spurred by a terrible itch to see the world and specifically explore how very-low-resource settings might grapple with maternal-fetal health. I had the great fortune to meet a couple of people who facilitated my volunteering for short stints, first in Papua New Guinea then Vanuatu. In between, I finished off a Master of Public Health I had begun during internship. I then returned to my tertiary hospital.

When I informed the hospital management of my intention to take my fourth year off training, I was asked to reconsider my decision. There was a cursory inquiry into what I intended to do and the repeated warning I might not have a job to come back to, despite my making it clear I did not expect this security. I was advised to avoid that risk. This experience reminded me that training registrars are often seen, first and foremost, as service providers. It also, I confess, made me wonder at how different it would have been if I had intended to take time off for family reasons. I celebrate how far our College has come in recognising that Trainees ought to have their childbearing needs catered to and also, more generally, in its approach to training flexibility. Surely, however, hospitals should provide similar levels of flexibility rather than focusing on the service delivery needs and potential for inconvenience.

Despite all, I was received back into my hospital readily enough for my fourth year. Then I went to Far North Queensland for a year as an outreach registrar; an experience I enjoyed immensely. For my final year, I returned to regional Victoria, partly for the surgical experience, mostly for the pleasure of working in a very well-oiled, compact unit with inspiring bosses. Towards the end of my training, I found a position in sub-Saharan Africa with Australian Volunteers International and spent half a year working as a lecturer and hospital specialist in Malawi. Just before leaving for Africa, I worked a few months locuming as a fledgling consultant in the unit where I'd been the senior registrar, feeling well-supported throughout. Since my return from Africa, I have done a few locum stints, and plan to settle down to a generalist position in the near future.

As described above, my entire career has been tailored to my needs and desires and has been hallmarked by flexibility. I have always harboured an interest in public health and have been able to explore this both academically and in clinical practice. I love seeing patients and working with my colleague doctors and midwives, but, equally, I crave time off to explore all that life has to offer. I plan to maintain a four-day work week for the rest of my career and am grateful every day that ours is a profession that will permit such indulgence.

Pacific perspectives on a woman's work

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I am a Pacific Island obstetrician and gynaecologist. I obtained my degree in 2005, and was registered as a specialist in 2007. I currently work as a consultant and assistant professor for the Fiji National University's College of Medicine, Nursing, and Health Sciences (FNU, CMNHS) at the Lautoka Hospital Medical Campus. I am mother to four-year-old twins and have a very supportive and loving husband.

The eldest of five siblings, I was born in Fiji but grew up in the Cook Islands. My parents live in the Cook Islands and my siblings live in Australia. Dad is a Cook Islander and retired surgeon. Mum is Fijian-Chinese and is an early childhood educator. Education was a big part of our lives and my parents were insistent that we complete our education so that we would be able to support ourselves and be independent. I grew up with that mentality of needing to complete school in order to be successful and happy. My mentality is different now. Life is not so compartmentalised and simple. I have grown to realise one never stops learning, success has different meanings to different people and happiness is personal.

The islands are a beautiful place to grow up. This is one reason why my husband and I have decided to remain in the Pacific to raise our children. We both grew up in the islands. My identity is that of a Pacific Islander: I know the language, the customs and the dance of my father's people. I have a similar knowledge of my mother's cultures. Despite experiencing the cultural prejudices of older relatives favouring our brothers and educationists doubting our abilities because we were girls, my sister and I grew up in a home environment that promoted equality with regards to education and opportunity, and household chores.

Our culture can be both supportive and counterproductive. Interwoven into most Pacific Island cultures is Christianity. The combination of culture and Christian faith plays an important role in my line of work. In some instances, it provides a supportive structure or coping mechanism for women and their families who have had an adverse obstetric or gynaecological outcome. Some may be so accepting of an outcome that they simply say: 'it was God's will'. Similarly, another situation that requires available medical intervention to avoid an adverse outcome may be met with the response 'we will leave it up to God' and medical intervention is declined. These instances require a great deal of patience, tact and reflection.

My undergraduate and postgraduate training was done at the Fiji School of Medicine, now called the Fiji National University. My Diploma in obstetrics and gynaecology was from the University of Auckland, New Zealand. I got this after failing twice. Lifelong friends were made during these years of training. As students we were treated relatively well and fairly by most medical and nursing staff; however, I recall, with little fondness, the males being favoured over the female students, particularly during attachments to the maternity units. The medical workforce at the time seemed to be predominantly male. There appears to be a slight shift in the gender balance nowadays and current FNU College of Medicine, Nursing and Health Sciences enrolment records a 60–66 per cent female intake.

After getting my specialist degree, I remember vividly a moment of overwhelming panic and despair. There were expectations of me to perform as a successful specialist, to role model professional behaviour, make a ton of money, find a suitable life-partner and have children. I made a conscious decision then to put all that on hold and went to work in Christchurch, New Zealand, for six months. Watching the rugby was an added bonus.

The Lautoka Obstetrics and Gynaecology

The author with her family.

Unit currently has nine female registrars, five female academic faculty, one private female specialist and two male consultants. Of the nine female registrars: two have completed postgraduate training, four are current trainees and the remaining three registrars hope to get on to the training program in the next year or two.

My academic duties require me to supervise and mentor undergraduate and postgraduate trainees in the field of obstetrics and gynaecology. In addition, I supervise international elective students, including James Cook University fifth-year medical students during their Fiji obstetrics and gynaecology rotation. Recently, Cuban graduates from other Pacific Islands have returned home and I was part of an FNU team that travelled to Kiribati every three months to conduct their internship assessments. During my time with the University I have been well supported and mentored and, as a result, have obtained a Graduate Certificate in Medical Education; been appointed the position of Adjunct Lecturer in the College of Medicine and Dentistry at the James Cook University, Queensland, Australia; and been invited to participate on two RANZCOG Committees – the Asia Pacific and Global Women's Health Committee and the CPD Program for O&G Specialists Advisory Committee. Later this year I hope to use an academic scholarship awarded to me by RANZCOG to further complement my clinical experience by attending the Anatomy of Surgical Complications Workshop in Perth in September.

My clinical duties involve conducting 7:30am teaching handover rounds for the unit, supervising obstetric and gynae ward rounds, antenatal and gynaecology clinics, elective gynae surgery, and doing a one-in-three consultant on-call duty roster. A recent on-call shift at 2am one Thursday morning involved devising a balloon tamponade using a condom, 16F Foley balloon catheter, feeding tube and normal saline to manage the atonic uterus of a 16 year primigravida who had delivered twins vaginally four hours earlier at a subdivisional hospital an hour away. I then managed to return home to have breakfast with the family before the twins headed off to kindergarten and then back to work for 7:30am handover rounds.

In 2012, the Fiji Obstetrics and Gynaecology Society (FOGS) was born. Since then it has held two annual scientific meetings that have been well attended by local and international participants involved in reproductive health in the Pacific. I am the Secretary and Treasurer for the Society.

The three roles I have as academic faculty, hospital clinician and Executive member of FOGS are well served when it comes to organising and participating in workshops and conferences in Fiji and around the Pacific. Examples of these have been ultrasound scan, laparoscopy and basic surgical skills, protecting the perineum in childbirth and perineal repair, intrapartum care, and emergency obstetric and neonatal care workshops. Most of these have involved overseas specialist facilitators or travelling to other Pacific Islands to facilitate workshops.

It is no easy feat juggling work and family commitments. There is no formula or app for this. Every professional wife, mother, clinician and academic has their own strategy or recipe for managing all their commitments. Perseverance, personal strength, a supportive partner and family, a supportive working environment and the confidence to accept that one cannot always be in control of everything all the time certainly helps. A quote I came across recently by the CEO for the Global Women's Fund, Kavita Ramdas says: 'We need women who are so strong that they can be gentle, so educated that they can be humble, so fierce that they can be compassionate, and so disciplined that they can be free.' This sums up the qualities I believe are necessary for me to manage my juggling act as a Pacific Island working woman.

Elective egg freezing: offering empowerment or false hope?

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Female fertility is extremely fragile, especially with respect to ovarian function and egg quality, and should never be taken for granted. The detrimental effects of female age on fertility and egg quality are predictable, relentless and unfortunately still currently resistant to medical intervention. Sadly, for many women towards the end of the reproductive lifespan, the opportunity to have a family, with their own genetically related children, has not been possible until now. Likewise, young women with cancer or other serious diseases, who require chemotherapy, radiotherapy or surgery, are at extremely high risk of infertility or even sterility as a consequence of this life-saving treatment.[1]

Over the last 20–30 years there has been an increasing commitment from the scientific and medical community to develop strategies to protect and preserve fertility, and thus expand reproductive opportunity in the future for women whose fertility is seriously compromised by increasing age, social circumstance or medical treatment.

The scientific advances in vitrification and survival of oocytes (eggs) and the increasing accessibility of egg freezing programs are now able to provide new hope for these women; but is it realistic hope or is it false hope? Just because we can now offer elective (non-medical) egg freezing, should we?

The medical, technical, ethical, social and economic implications provide rich fodder for discourse. Healthy debate should avoid personal prejudice and social judgement, and focus instead on the bigger picture. This includes both recognising the basic liberty right to have the opportunity for a family and also understanding the importance of reproductive autonomy.

Female ageing and fertility

A reduction in egg number and the increasing genetic and metabolic fragility of eggs are both implicated in normal senescence. However, the importance of the biological clock has become more relevant in contemporary society, as we partner later and have our children later, with the associated age-related risks of reduced fertility, miscarriage and other complications. There is a common misconception (pardon the pun), that fertility treatment and IVF will help age-related infertility, but to date no scientific treatment available in a clinical setting has been shown to improve egg quality.

Motivations for egg freezing

While there is a populist view that the average woman who is interested in egg freezing is career-driven, with no time to conceive at a reproductively appropriate time, the reality is very different: for many women, the motivation stems from a current lack of opportunity to conceive, despite a strong desire to have a family or at least the choice to have a family. Most women are not in a relationship, not in a suitable relationship or are recently separated, having expected to have children with their ex-partners.[2,3]

The science of egg freezing

Until fairly recently, the technique employed for freezing and thawing eggs (namely slow-freezing) resulted in suboptimal survival and hence numerically little opportunity for conception. Although the first birth from a frozen-thawed egg was reported in 1986[4], further success has been elusive until the last 10–15 years. The high water content in eggs provides a challenge and slow freezing is associated with development of ice crystals, chilling injury and osmotic damage contributing to poor viability after thawing.[5] However, the development of vitrification, which uses high freezing and cooling rates to avoid ice crystal formation, means that survival of eggs exceeds 80–90 per cent.[6] Vitrification is now almost universally used in egg freezing programs worldwide.

The success of egg freezing

With excellent survival now established as a result of vitrification, it is reassuring to know that, once an egg survives the freezing-thawing process, it behaves as a fresh egg, with comparable fertilisation, implantation and pregnancy rates[7], and no apparent increase in abnormality rate.[8] Frozen eggs are used in most of the big egg donation programs in Europe and the US with great success.

However, it is extremely important to understand that, exactly as with fresh eggs, there is a high rate of expected attrition with the progression from mature egg to usable embryo. Approximately 50–60 per cent of eggs will fertilise and then there is further attrition during development of the early embryo. So for every ten eggs that are frozen and thawed, two to four will develop to early embryo stage (day 2–3) and possibly only one to two embryos will progress to the blastocyst stage (day 5).

It is conservatively estimated that between 15 and 25 eggs would be required for one baby in a woman who undergoes freezing under the age of 38 years[9], and this may involve one or more cycles of stimulation and cryopreservation.

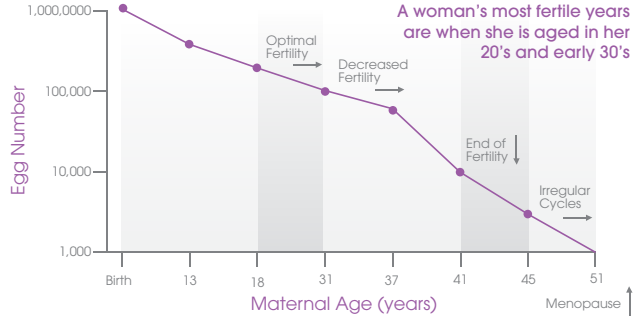

Figure 1. Female fertility decreases with age.

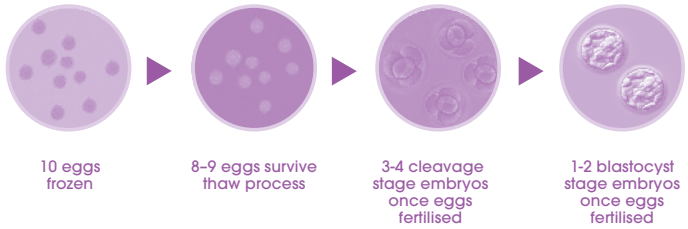

Figure 2. An illustration of the typical attrition rate for egg freezing.

While the average number of oocytes obtained per cycle is 10–15, consideration of age, anti-Mullerian hormone (AMH) and follicle stimulating hormone (FSH) level and ultrasound assessment of follicles, can all assist in predicting the result for an individual woman.

As women age, they will respond to ovarian stimulation with fewer egg numbers, so on the whole, egg freezing is not offered to women over 38 years of age. However, there is room to allow individualisation of decision-making, such that if a woman older than 38 has excellent ovarian function with a high yield of eggs expected, the technique can be considered.

The biggest challenge when counselling women who request discussion about egg freezing is to ensure that they understand that even with a good number of eggs frozen, at most this technology will offer a small, finite number of additional opportunities to conceive in the future. So this must not be relied on as a form of reproductive insurance and women need to understand the perils of making subsequent life decisions to delay fertility on the basis of having some frozen eggs.

Notwithstanding the words of caution, egg freezing is acknowledged as a technique that has come of age and is no longer viewed as experimental.[10] This may be why some US tech companies now offer the opportunity for egg freezing to their female employees, prompting vigorous debate about the competing motivations of coercion versus enlightened employment packages.

Box 1. AMH

- produced by small follicles in ovary;
- used as surrogate marker of primordial follicles and hence ovarian reserve;
- much variation between assays;
- does NOT reflect quality of oocytes;
- Can still conceive successfully with very low level; and
- gives very vague indication of expected yield in ovarian stimulation.

Timing for egg freezing

Paradoxically, in order to maximise egg numbers and offer a substantial opportunity to later conceive, egg freezing is best undertaken at a relatively young age, when fertility or even future fertility is not yet a consideration. A woman of 25–30 years of age will generally produce a much larger number of eggs, with more robust genetics and thus far greater implantation potential, than a woman over the age of 35.

Most women, however, who come to have discussion are already in their mid-late 30s or even over 40. They come because life has not turned out the way they would wish, they are not in a position to have a baby, either as a single woman or with a partner, and often they are already grieving their loss of fertility potential. In this situation, we need to consider the benefits of going ahead versus not going ahead. While the chance may be relatively low of obtaining enough good quality eggs, it certainly provides more opportunity than NOT going ahead. Also, many women feel reassured by having done everything they can to aid future fertility and this feeling of control is very important to them, as it may help reduce the desperation to find someone to reproduce with.

Ideally, however, we should consider a societal shift. If we could turn things around and consider the option of egg freezing at a much younger age, viewed as an opportunity to plan ahead, just in case things don't work out, there would be much more positivity associated with the concept, not to mention a more realistic chance of success.

The practicalities of egg freezing

Assessment

Women who are interested in maximising future fertility need to be evaluated for any reproductive risk factors, significant past history and relevant family reproductive history. It is possible to assess current ovarian function and get some idea of ovarian reserve by a combination of endocrine parameters (day 2 FSH and AMH) and early follicular phase ultrasound. Interpretation of AMH levels is extremely problematic and caution should be employed (see Box 1). Many women are reported as having impaired ovarian reserve, but this only reflects the normal attrition associated with ovarian ageing.

The evaluation should include discussion of the woman's fertility aspirations, plans for the future and other options, including consideration of getting on and having a baby (with donor sperm if required) in the late 30s or early 40s.

Counselling should be performed, including a frank discussion of expected yield and how much genuine additional opportunity is likely to be provided by uptake of the process. Access to a reproductive unit counsellor as well as a medical specialist may be useful.

The process

Technically, an egg freezing cycle is much like an IVF cycle, involving hormone stimulation with FSH for 10–14 days to stimulate development of multiple follicles to maturity. An additional injection of a gonadotrophin-releasing-hormone antagonist (GnRH) is used for the last 3–6 days of stimulation to prevent premature ovulation of the more mature follicles. An injection of recombinant human chorionic gonadotrophin (hCG) is given 37 hours before the procedure to trigger completion of meiosis I and initiate meiosis II, and to prepare the follicles for imminent release. The oocyte retrieval takes place about day 12–16 of the cycle, usually under sedation, via a trans-vaginal approach. Patients are discharged home approximately an hour after the procedure, with instructions to take it gently for a day or so.

The risks

Fortunately, undergoing ovarian stimulation and oocyte retrieval does not use up eggs or predispose to earlier menopause. The

hormone stimulation is associated with an extremely small risk of thrombosis (of the order of 1/5000) or infection (1/5000). Ovarian hyperstimulation syndrome has fortunately been reduced to an almost negligible risk, thanks to careful practice and the availability of an alternative (GnRH agonist) trigger injection if required. The common symptoms of bloating and fullness resolve over a few days and patients expect to feel completely back to normal within 7–14 days after the procedure. As discussed, the major risk associated with this is the misguided reliance on a small supply of frozen eggs as a guarantee of future fertility.

The cost

There is no Medicare reimbursement for non-medical egg freezing and the costs vary between centres, but are in the vicinity of $8000–12 000 for a cycle, with storage costing $200–500 per year.

Conclusions

The best chance of having a baby involves spontaneous fertility in the mid to late 20s or very early 30s. This opportunity may not be available to some women for a variety of reasons and thus fertility preservation by egg freezing may offer these women a realistic chance of having their own child in the future. The magnitude of the additional opportunity will be related to the age of the woman at the time of the freezing, the number and the quality of the eggs frozen.

We can advise our patients about the expected benefit, but we must make sure that we do not judge them. For some women, any extra chance of future fertility is better than none, as long as there is no false hope which affects subsequent decision-making. The value of allowing women the opportunity to take some (even just a tiny bit) of control over their reproductive future cannot be underestimated.

It is likely that within the next few years, we will see more young women adopting a proactive approach, considering egg freezing before the commencement of the fertility decline. It is imperative that this does not perpetuate the societal pressures that predispose to high maternal age. We must continue to strive for better conditions for combining early childbearing with other professional aspirations and life goals.

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When the professional becomes personal

Confessions of an obstetrician

Sitting in the antenatal clinic of a large public hospital, I look silently at the patient across the desk. Tears welling up, she is looking at me with pleading eyes. 'I don't want a vaginal delivery', she says. 'I don't understand. Why I can't just choose to have a caesarean section?' I give her one of the usual explanations: it's a public hospital, priority of spending, against policy, elective is a major procedure with major risks. Then she pulls out the final card: 'What would you do?'

I smile and try to reassure her that everything will be fine, while inwardly the guilt rises, because I know what I would do; because I have made my choice – twice. I chose an elective caesarean section. It feels like the confession of the guilty. When I booked in for my obstetrician's appointment I felt nervous. I really didn't want a vaginal delivery. What was I going to say? In my carefree years and pre-pregnancy life, I believed in the rhetoric of no elective caesarean sections by choice. However, as time went on, night after night of suturing third- and fourth-degree tears, poor neonatal outcomes, crash emergency caesarean sections, I also came to believe that bad things just happen without it being anyone's fault. Don't we have to believe that as well, as obstetricians?

Two years of trying, four miscarriages and multiple investigations later we finally had our chance at a 'miracle baby'. It was a one in 10 000 chance, one obstetrician told me. What risk was I prepared to take? Absolutely none. Would I have still chosen the same path if it had been an easier one? Almost certainly, yes. Luckily for me, my obstetrician asked me what would I like to do – vaginal delivery or caesarean section – and with relief I booked in my caesar date. As the pregnancy progressed, we held on to that date, each scan one step closer, hoping that each antenatal visit wasn't bringing bad news. Finally, the call: 'I think, taking into consideration everything, we should just bring the caesarean date forward – to today.'

I don't regret my decision for one moment. It was a relief to see a healthy baby arrive safely and at the end of the day that was all I wanted. What did I learn from my caesarean section experience? The antiseptic solution used to prep for the spinal is really, really cold, not just cold. It's the worst feeling in the world when your blood pressure drops to zero. The recovery was more painful than I expected, but not unmanageable. You do feel completely ridiculous trying to get up sideways to avoid using abdominal muscles. And, finally, I had no idea what was going on behind the screen at any point despite knowing every step back to front.

I still feel the excuses come when I'm asked why I had a caesarean section. I feel annoyed sometimes that I get questioned about my decision as it seems a personal and private question is not so private or personal when you're an obstetrician. It feels like the question isn't always about me and my decision, but about the wider community opinions for and against elective caesarean sections. Somehow my answer will justify an argument for one or other side.

Back to the antenatal clinic. I still believe caesarean section for maternal request should be declined. I still believe the public hospital just couldn't handle the workload if it offered a caesarean section as a routine and that many women don't limit family size and, as we know, the risks go up in this circumstance, but I'm a little more willing to find out why she wants it and try to find a solution behind the concerns and I am a little more likely to agree if I there seems to be a legitimate concern. Ultimately, I am pro-choice and feel a twinge of guilt and regret accompany my 'no' answer.

Dr Anonymous
FRANZCOG

The benefit of shared experience

When it came to starting a family, the decisions I struggled with most were where to fit this into my training and whether to have prenatal testing. I didn't so much

choose vaginal birth, rather it was the general expectation that it would happen that way.

Although in my early 30s, I decided the membership exams had to be behind me before I started my family. I didn't believe motherhood should compete with study as well as shift work and long hours. Post-membership I embarked on my first and, as it turned out, only pregnancy. It was planned with precision and the estimated due date conveniently fell between registrar six-month training periods.

In the mid-1990s nuchal translucency for aneuploidy screening was only just being introduced. I was below the accepted age cut off for diagnostic testing, but decided to have an amniocentesis. I don't know how I had the courage to go through with it given the not insignificant risk of pregnancy loss. Only in retrospect do I appreciate how much was at stake.

Having agonised over the amniocentesis decision, the mode of birth was never a big consideration for me. I was confident in the knowledge that my mother had had four children naturally, delivered by a rural GP. I conveniently overlooked the fact that I was at least ten years older having my first child, but nonetheless I was what is now regarded as a standard primigravida.

None of my contemporaries were debating the option of planned caesarean section. Senior female colleagues and the wives of male specialists had embraced vaginal birth as the norm, unless there was a clear indication for the alternative. The antenatal women I cared for were content to do the same. The spectre of perineal tears or future pelvic floor functionality was uncommonly discussed and generally not considered sufficient reason to request a caesarean section.

I had seen tragic perinatal events, but I didn't believe this would happen to me. I had a midwife and specialist obstetrician and was planning to deliver in a well-equipped hospital. I had complete faith in the practitioners caring for me and the safety net provided.

I didn't have the precipitate normal birth I had optimistically counted on. There was induction of labour for obstetric indication at term. All the pain relief options available were trialled including, ultimately, an epidural. My baby girl was born safe and well following straightforward instrumental assistance. There were no short- or long-term postpartum sequelae.

I have no regrets about having a vaginal birth and I'm grateful I am able to share this experience with the women I care for. The only regret I have is that I ran out of time to have more children. Trainees, I hope, will heed advice that completing family should be a priority over training and job prospects.

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Working safely while pregnant

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Jessie O'Mahony
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Pregnant women seeking information about the safety and suitability of their work expect to receive clear advice about workplace risks. For most women with uncomplicated pregnancies, the type of work they perform does not pose any specific health risk to them or their babies. Some workplace pregnancy health risks, such as exposure to ionising radiation, are well known; however, in many jobs there is a relative lack of research and good quality evidence. This article provides an introduction to, and resources for, assessing fitness for work during pregnancy. The process includes considering individual risk factors, an assessment of the workplace hazards and appropriate risk communication with the woman and, where appropriate, her employer. While evaluating potential work-related health risks doctors should also be mindful of the health benefits of good work.

Managing workplace risks

The ideal solution is to eliminate any hazard from the workplace that could affect women of reproductive capacity. Where that is not possible then risks must be minimised and managed. The model Work Health and Safety Act states that employers have 'a duty of care to ensure health and safety, so far as is reasonably practicable, by eliminating risks to health and safety. If this is not reasonably practicable, risks must be minimised so far as is reasonably practicable.' Workplaces should have policies and procedures that comply with all relevant laws, including equal employment opportunity and diversity legislation.

Pregnant women in most roles are not legally obliged to inform their employer they are pregnant. However, if there are potential workplace hazards then it is best for discussions to occur as soon as possible. Where necessary, the duties may need modification or adaptation. In some circumstances, the worker may need to be provided with an alternative role. In some safety-critical roles, for example, commercial aviation and in the armed forces, women may be required to notify the organisation as soon as they know they are pregnant to ensure safety. It is important to consider the expectant mother's understanding of the hazards in her workplace as that will influence the nature of discussions, particularly in situations where it is difficult to quantify risk.

Individual factors

There is a range of individual factors that can impact both the pregnancy and fitness for work. Some examples include:

- pre-existing medical conditions, for example hypertension and diabetes;
- specific pregnancy-related conditions, for example morning sickness, placenta praevia or multiple pregnancies; and
- mental health conditions, for example perinatal depression.

Evolving risks during pregnancy

Fitness for work can evolve during the course of a pregnancy. For example, the capacity to perform shift work or to work in hot environments can be affected during the first trimester by symptoms of morning sickness and fatigue. Standing and lifting capacity may be reduced during the second trimester, owing to backache and increased weight. During the third trimester, increased abdominal girth may preclude tasks such as confined-space work and other physically demanding duties. The risks to the fetus evolve through the different stages of development. For example, exposure to ionising radiation is of greatest concern during the first trimester, whereas it is thought that exposure to excessive noise may be a greater risk after the fetal cochlear has developed in the second trimester.

Hazards and clinical resources

Some workplace hazards, such as lead and cytotoxic drugs, are well known and the risks have long since been recognised. Any workplace where such hazards are present should have clear, established procedures in place to protect women of reproductive capacity. There are, however, many potential workplace hazards where there is limited evidence or the risks are uncertain. Table 1 shows selected examples of workplace hazards together with references and links to useful clinical resources.

Ergonomic advice

Questions are commonly asked about physical work activities. The Society of Obstetricians and Gynaecologists of Canada advises the doctor, nurse or midwife may recommend changes if work involves the following:

- stooping or bending over more than ten times each hour;
- climbing a ladder more than three times during an eight-hour shift;
- standing for more than four hours at one time;
- climbing stairs more than three times per shift;
- working more than 40 hours per week;
- shift work;
- lifting more than 23kg after the 20th week of pregnancy;
- lifting more than 11kg after the 24th week;
- stooping, bending or climbing ladders after the 28th week;
- needing to lift any heavy items after the 30th week; or
- needing to stand still for more than 30 minutes of every hour after the 32nd week.

Further discussion and assessment may be warranted in individual cases. An ergonomic assessment of the pregnant woman's

Table 1. Examples of workplace hazards and clinical resources.

Hazard type	Examples	Clinical resources
Physical	Ionising radiation	Health and Safety Executive, Working safely with ionizing radiation, Guidelines for expectant or breastfeeding mothers, www.hse.gov.uk/pubns/indg334.pdf
	Noise	Centers for Disease Control and Prevention, Reproductive Health and the Workplace, www.cdc.gov/niosh/topics/repro/noise.html
Biological	Infectious diseases	Infection Risks to new and expectant mothers in the workplace, HSE Advisory Committee on Dangerous Pathogens, HSE Books, 2005, www.hse.gov.uk/pubns/priced/infection-mothers.pdf
Chemical	Organic solvents, anaesthetic gases, pesticides and lead	The Motherisk program, the Hospital for Sick Children, Toronto, www.motherisk.org/women/occupationalExposures.jsp
Ergonomic	Prolonged working hours, shift work, heavy physical workload, prolonged standing or sitting	Royal College of Physicians, UK. Pregnancy: occupational aspects of management. February 2013, www.rcplondon.ac.uk/resources/pregnancy-occupational-aspects-management
Psycho-social	High job demands with low control	Psychosocial Assessment and Depression Screening in Perinatal Women, Marcé International Society Position Statement 2013, www.ranzcog.edu.au/college-statements-guidelines.html
	Violence, harassment and bullying	Australian Human Rights Commission, Workplace bullying: Violence, Harassment and Bullying Fact sheet, www.humanrights.gov.au/workplace-bullying-violence-harassment-and-bullying-fact-sheet

workplace may provide recommendations to reduce or eliminate risks.

Workers flying to remote locations

Working in remote locations is not uncommon in Australia and doctors providing advice to pregnant workers should have access to information about the care available regionally if a complication was to occur. After 28 weeks, women need to carry a letter from a doctor or midwife, dated no more than ten days before travel, confirming fitness to fly, the estimated due date, single or multiple pregnancies and the absence of complications. Individual airlines have different recommendations; however, they commonly advise that for flights of four hours' duration or greater, for routine pregnancies, women can travel up to the end of the 36th week for single pregnancies and to the end of the 32nd week for multiple pregnancies. On flights less than four hours' duration, for routine pregnancies, most say women can travel up to the end of the 40th week for single pregnancies and to the end of the 36th week for multiple pregnancies. After delivery, medical clearance is required for travel within seven days.

Return to work after maternity leave

Returning to work after maternity leave can be influenced by a range of factors such as breastfeeding and fatigue. Women with perinatal depression can experience difficulties with cognitive work performance. In such cases, an individualised vocational rehabilitation plan can be developed to establish a suitable and graded return-to-work program.

Complex cases

In the assessment of complex fitness for work cases, occupational physicians can assist treating obstetricians and general practitioners by using their training in ergonomics, toxicology and risk communication. After assessing the patient, informed consent is obtained to liaise with the employer. A site visit to the workplace can assess the role, identify hazards and quantify risks as part of a structured risk assessment process. The goal is to negotiate an individual, agreed and safe work plan. Monitoring and reassessing fitness for work as the pregnancy progresses is part of the process.

Acknowledgements

I acknowledge the work of Dr Caron Jander, FAFOEM, in leading the preparation of the Australasian Faculty of Occupational and Environmental Medicine (AFOEM) Position Statement on Pregnancy and Work, with input from the AFOEM Policy and Advocacy Committee and the staff of the RACP Policy and Advocacy Unit.

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When career women have children: psychological issues and assistance

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My clinical notes for women experiencing stress, anxiety and depression in the postnatal period are littered with the expression 'I want my life back'. The change from paid work to full-time motherhood can be a joyful experience, where many women report being happy to be at home with their children, but for others it can be a time of emotional upheaval and even mental illness.[1,2,3]

Having a baby and parenthood can be stressful life events. The moral and social expectations set for mothers about their role and the 'acceptable feelings' they should go through can be a burden when they do not match with their own experiences.[4]

Going from a time when they had relatively more freedom to choose what to do in a week, day or hour, to addressing the baby's needs first can be oppressive. These feelings can be amplified by the fact that many women are having children later and have already made strong headway in their chosen work or career.[5]

Generally, the majority of primary caregivers to babies and young children – single or in a relationship – are women. This entails either being a full-time mother or working paid part or full time in addition to mothering – the latter often a difficult juggling act between competing priorities. In couples where the woman has previously had a busy career, there are common concerns and issues surrounding stay-at-home mothers.

While not the focus of this article, it is the case that pregnancy itself can present potential problems and stressors for women that need to be managed while working. How these are dealt with can also impact the postnatal period. Some mental preparation for the role change and challenges of the postnatal period is also important in the antenatal period.

Many of my clients fit the category of full-time mother previously full-time career woman. One is a 37-year-old environmental scientist who has travelled the globe advising on sustainable agriculture. She adores her baby and loves being at home, but her experience of full-time motherhood – and an impending return to work – is a game of juggling parenthood, a professional life and career development. For those mothers at the beginning of their time at home or for those who choose not to return to paid work, the experience is challenging.

Common themes

All women need to adjust to motherhood. Most will experience some stress, but some go on to develop or exacerbate more serious mental-health issues such as generalised anxiety, obsessive compulsive disorder and mood disorder.[6,7]

Sleep deprivation and settling baby are naturally an issue. The seemingly relentless nature of caring for an infant can be hard when previously used to having some sense of control in their daily life and attempts to control the situation can sometimes end in greater stress.[8]

Women who are drawn to certain career roles are all after similar 'payback' from fulfilling these roles – status, money and the power to achieve. Personal sense of worth flows from these roles. Contrast this with the sudden social and professional isolation that can accompany new parenthood and you can see the vital importance of role adjustment. The current political and economic imperative to get women back to work also contributes to devaluing the role of the primary carer and is often cited by women who stay at home.

Women who describe themselves as high achievers at work can experience varying effects on how they manage their expectations of themselves (for example, breastfeeding), their baby (for example, settling) and their partner and family. It is common for perinatal women feeling anxious and depressed to believe they are not doing a good job, that they have failed as a mother and that other women are much better at mothering. This can become circular as sometimes they are indeed not mothering to their potential when anxious and depressed.

Comparisons with other mothers or families are rarely favourable in women who are anxious or depressed in the postnatal period. At the more worrying end of the spectrum, mothers express the belief that their baby – and often partner – would be better off without them. Some talk about running away and escaping and more concerning is when they consider suicide as a means to escape or cope.[9,10]

Women can describe also feeling trapped or experiencing grief over the loss of their past life, including financial independence. Most women in Australia have access to some form of maternity leave, but even when they do this money runs out. The majority also report difficulty in asking their partner for money, with some resultant resentment.

If women are not coping or enjoying motherhood, feelings of guilt and shame are experienced – particularly for those who always thought they would love being a mother. Those who have endured fertility problems can feel significant guilt and confusion when they question why they have had their baby or resent their role.[11]

The need for a social life can become very important to a stay-at-home mother. However, as her friends may not have children themselves, she can feel misunderstood. It is also hard to get babies and children out in the first place, impacting on the ability of a mother to socialise. Additionally, if a mother is very anxious about sleep and routine, fear her baby will not sleep means she stays home. For others, feeling depressed makes it less likely they want to socialise and the pattern continues.

The reported impact of new babies on partner relationships is significant in the perinatal period. The correlation between relationship adjustment and functioning is high, so it can be useful to determine if the anxiety and mood issues are a factor in the relationship issues or if the relationship issues are themselves causative of the mood and anxiety problems. Once entrenched, though, it can be difficult to separate the causes.[12,13,14]

> 'At some stage, most women dealing with the changes of motherhood might ask: can you really have it all?'

It is also important to recognise that partners can also suffer postnatal mental health issues – the assessment of which is important for individuals as well as the impact it has on the functioning and wellbeing of the mother and infant.[15]

The issue of childcare provision for women working after having a baby is another stressful factor. Choosing a type of childcare and getting a position can be time consuming and difficult, along with the emotions that go with having a child cared for by someone else, including guilt, anxiety and relief.

Can you really have it all?

At some stage, most women dealing with the changes of motherhood might ask: can you really have it all? Given they were told they could as they grew up, why not? The reality of this balancing act is often very difficult and most women will say they have not got it right. Feeling a sense of failure and believing they are not doing well enough at work and at home can be overwhelming.

Some stay-at-home mums never adjust to, or like, the role change, resenting being at home and not wanting to be full-time carer for their baby. While this is worrying in terms of mother-infant attachment, we cannot ignore this as a choice. While the mother needs to be able to validate these feelings in a non-judgemental way, it must be ensured that her baby is getting its attachment needs met and the woman is supported on her return to the workforce. In fact, once she returns to work her perspective on mothering may change.[16]

Identification of psychological issues

The mental health of a mother affects greatly that of her baby, older children and partner. All mothers want their family to be happy and healthy. This is not only a motivator for change, but can also put more pressure on a mother to be well.[3]

Severe, chronic stress has been shown to deleteriously affect maternal and fetal

health, while management of stress in pregnancy has been shown to be efficacious in reducing perinatal stress, anxiety and depression.[17] Evidence in the literature indicates psychological distress, depressive and anxiety symptoms are related to increased risk of adverse outcomes for mother and child during and after pregnancy.[18] In the postnatal period not only the mother suffers, but her relationship with her infant and the infant's ongoing emotional and cognitive development may also be affected by mental illness.[19,1]

Some of the important factors affecting the duration of postpartum depression and anxiety include preventative measures and minimising the time taken to recognise and receive adequate treatment.[19] Identification of depression and anxiety in the postnatal period can be hard to detect as it is often suffered covertly.

In assessing a woman in the perinatal period, it is important to complete a full psychosocial assessment. If postnatal, an assessment of mother-infant interaction and assessment of risk to mother and baby is also required.[20]

A forward-thinking and collaborative approach to management of psychological issues is about identifying women who may be at risk and commencing treatment before birth or as soon as possible once symptoms commence in the postnatal period.[21] Obstetricians, midwives, maternal and child health nurses and GPs are in a good position to identify women of concern. Use of screening tools such as the Edinburgh Postnatal Depression Scale (and its antenatal version) is appropriate.[22]

There is a large amount of literature identifying risk factors and predictors for perinatal mood and anxiety problems. Rarely is a single factor explanatory of a woman's current mental state. The reality is a combination of many factors – biological, social and psychological. These include personal and family history of mental health issues, personality style, relationship stress and social support.[23,20,7] If a woman is seen to have a number of risk factors in the antenatal period then this is a good time to refer to help. Much work and preparation can be achieved in the time before the baby is born. Generally speaking, helping in adjustment to the role of mother and managing expectations in pregnancy and the postnatal period is important.

During the perinatal period, women presenting to a psychologist often report no previous history of anxiety or mood disorder. However, many have suffered anxiety at a high level and sometimes depression in the context of her work, relationships or other situations that are stressful that was undiagnosed, untreated or mainly considered – in the case of anxiety – a useful feeling that motivated and helped them achieve. The combination of recovering from the birth, a lack of sleep and the demands of parenthood can mean anxiety is no longer manageable and affects their functioning.[24,25]

Part of helping a mother involves education about the effects that her mental health can have on her baby and, if it is the case, her other children. However, it is not helpful to make them feel any more guilty than they often already do. Mothers seeking or being referred to help are sorely aware of the impact and it is this that often stops them seeking assistance initially.[26,9] In those cases where the mother is so unwell – such as in severe depression and psychosis – the insight into the effect on her baby can be lacking, the resultant education should be given clearly, but with her capacity to assimilate this information taken into account.

Work around self-care, realistic expectations and acceptance versus change is helpful in managing feelings of being overwhelmed and/or trapped or isolated. Getting partners and other family members involved can make a significant difference.[27,12] Encouraging socialising – and for some more formal connections such as mothers' groups and playgroups – can open up the social world significantly. Activation with physical exercise and involvement in community is encouraged. Addressing longstanding issues that have become more obvious in the perinatal period is valuable when reflecting on current feelings and resulting behaviour.

Referral to antenatal and postnatal support groups on parental adjustment is useful. Groups that offer support to mothers in the postnatal period if they are suffering from emotional issues and mental illness, such as PANDSI, are remarkably helpful. Numerous websites give good information and support to mothers experiencing perinatal distress (for example, the PANDA and beyondblue websites).

Therapeutic approaches

A supportive and flexible therapeutic environment is paramount to successfully working with a woman in the perinatal period. Many women will not openly disclose they are having difficulty for fear of the stigma, a desire to remain in complete control, worry about asking others for help and concern they will be seen as unfit to care for their baby.[28,29]

Cognitive-behavioural therapy (CBT) interventions have been shown to have positive effects in the antenatal and postpartum period with the relationship between thoughts, feelings and behaviour being the focus.[30,31] Treatment using mindfulness-based cognitive therapy[32,33,34] as well as acceptance and commitment therapy[35,36,37] in the perinatal period is also extremely useful. Women appreciate the opportunity to learn about being present with their baby and their life more widely and about values-based choices in their role as a mother, partner and in work. They learn about what they need to accept and what they can change and they learn to take action while managing their thoughts by defusion.

The use of schema therapy[38] – an approach that combines aspects of cognitive, behavioural, psychodynamic and attachment models – can help women at any stage of their life identify and address specific schemas, coping styles and modes that have developed since childhood. This can offer great insight for a woman in terms of her interaction with her baby as well as her patterns of thoughts and actions. A woman's upbringing and relationships with family, particularly her mother, is very important at this time.[9] Furthermore, a history of abuse has great impact on her parenting and benefits from being addressed.

Interpersonal psychotherapy (IPT)[39] has long been used in the assessment and treatment of perinatal depression. The focus on relationships and communication, role transitions and interpersonal disputes is especially helpful when a woman experiences much change in role and relationships. Grief and loss are also addressed and this is particularly appropriate for addressing loss of a baby, miscarriage and babies with special needs or requiring time in the NICU, for example.

The requirement for assessment and treatment for trauma in the perinatal period is becoming increasingly recognised.[40] Many women (and sometimes their partner) experience aspects of the pregnancy and birth and the immediate period after the birth as traumatic. The birth of a baby compromised with a medical condition or born at a stage that requires NICU is also traumatic often for reasons of helplessness and horror for their baby and the treatment they need to receive.

Pharmacologic treatment of mental illness in the perinatal period is also an essential part of treatment success, particularly at the more serious end of disorder. Specialised knowledge is required of psychiatrists, specialist perinatal mental health services and primary care physicians in providing this assessment and advice in addition to psychological assistance. Working in conjunction with a psychologist or counsellor who offers psychological intervention is highly desirable.[41,42,43]

Conclusions

The birth of a baby to a woman who is leading a productive, paid working life will open up a world of new experiences. While many of these are described as wonderful by full-time mothers, there are also some that cause severe stress and at times anxiety and depression. Identification and help as early as possible for women having these experiences is essential for their mental wellbeing and the wellbeing of their baby, partner and family.

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Domestic violence and its impact in the workplace

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Domestic violence is a major health, legal, social and economic issue for our community. It is the leading preventable contributor to death, disability and illness in Victorian women aged 15–44 years old.[1] The overwhelming majority of victim/survivors are women and the highest risk times are during pregnancy or post separation. For women who experienced partner violence: 54 per cent reported experiencing violence by a previous partner during pregnancy and approximately 25 per cent for the first time while pregnant.[2]

Domestic violence is essentially an abuse of power by a family member that can take many forms, including intimidation, threats, coercion, control, isolation and emotional, physical, sexual, spiritual or financial abuse. Domestic violence is common. Victoria Police attend 385 incidents related to family violence per week.[2]

Domestic violence and the workplace

The International Violence Against Women Survey (IVAWS) found experience of domestic violence varied little according to education, status or household income.[2,3] Up to two-thirds of women who report violence by a partner are currently in paid employment. Domestic violence can disrupt the economic lives of working women and can, therefore, serve to make women more dependent on the perpetrators of the violence and less financially independent.

Domestic violence can also occur in the workplace. The perpetrator may feel that he needs to assert control over the woman and make her dependent, thus her work is an impediment to his control. Attending work can make a woman particularly vulnerable, since there is a set location and work hours, often with easy public access for the perpetrator. Repeated unwanted attention that is intimidating and creates fear is commonly experienced at the workplace. In severe cases, murders within the context of intimate partner violence have occurred at work.[4]

An employee experiencing domestic violence is likely to struggle with decreased work performance. Controlling behaviour by the perpetrator may include monitoring the victim/survivor through phone calls, emails, texts and in person. The victim/survivor may require increased leave, including sick leave and leave for medical, and legal consultations and court appearances. Perpetrators have been reported to interfere with women's work efforts through sleep deprivation, inflicting injuries, reneging on agreements around childminding and physically preventing women from leaving their homes.

Of those surveyed, 25–50 per cent of victim/survivors report having lost a job partly owing to family violence.[6] Victim/survivors may be disadvantaged in the labour market owing to disrupted work histories and are more often employed in part-time and casual work.[7]

Domestic violence is one of the leading causes of homelessness, with up to 30 per cent of all Australians receiving assistance from homelessness services citing domestic violence as the reason.[5]

Responses

Health Justice Partnerships

The disease burden attributed to 'unjust inequalities' reaches at least 17 per cent in Australian studies.[8] Our patients who present with a medical issue may also have underlying legal problems that need to be addressed in order to improve their health and wellbeing. Victim/survivors are particularly vulnerable to substantial and multiple legal problems and they often face barriers to accessing the legal system. Doctors can no longer ignore the importance of legal assistance in improving health outcomes for their patients. Australian research shows in the region of 27 per cent of people requiring legal services turn to a trusted healthcare or welfare provider for advice.[9] Studies in the USA have found that increased provision of legal services was one of three key factors contributing to the decline of violence against women by their intimate partners.[10]

Boston-based paediatrician Dr Barry Zuckerman was the pioneer who, in 1993, created a model to integrate free legal advice into a medical clinic.[11] This model has been replicated in 276 healthcare institutions in 36 states across the USA.[12] He has unleashed a global phenomenon that has now been embraced by innovative Australian healthcare and legal providers: Health Justice Partnerships (HJPs).

Acting on the Warning Signs

Inner Melbourne Community Legal (IMCL) is a not-for-profit community organisation

that has been a foundation player in the creation of HJPs in Australia. IMCL currently conducts several HJPs providing free legal advice to patients including one at the Royal Women's Hospital (RWH), the Acting on the Warning Signs Project (AWSP). The great bulk of the legal work performed at RWH involves patients with family violence issues.

A major role of the AWSP is the education of health professionals to recognise and respond to patients who have been subjected to domestic violence. To date, more than 200 members of staff have been trained. Specific training for doctors has also been developed and received RANZCOG accreditation, with almost 30 doctors taking part to date.

From 1 July 2012 to 25 May 2015, IMCL provided 214 instances of legal advice onsite at the RWH. For over half of those, the lawyer considered that the client may have been affected by family violence.

The majority of issues arising at the onsite legal service include birth certificates, family law and child support, child contact and divorce, family violence, and fines. A number of other issues have also arisen, including: consumer complaints, credit and debt, discrimination, DNA testing, employment, government pensions/benefits, criminal matters and tenancy. IMCL does not provide assistance to patients in relation to complaints against the hospital; medical negligence; business and commercial matters or personal injury matters such as TAC or WorkCover.

Many of the patients seen by IMCL lawyers are vulnerable and disenfranchised and a substantial number are unemployed or struggling in low income, casual or insecure employment. We have chosen a case to illustrate the complexity and difficulty of their personal and economic lives – see Box 1.

How can clinicians respond?

Doctors may feel impotent in helping women – whether they are patients, co-workers or employees – with domestic violence issues. They fear that they are involving themselves in a private matter that has no relevance to work or they do not have the skill set to handle the situation.

There are several ways in which we can make a practical difference to decrease the risks of domestic violence. The World Health Organization (WHO) identifies LIVES as a practical reminder of core elements of first response in situations where a clinician suspects that a woman may be impacted by violence.[13] There are five core components of LIVES:

1. Listen
2. Inquire about needs and concerns
3. Validate
4. Enhance safety
5. Support

The areas of response are relevant in the context of a patient-clinician response or, more broadly, for example, in interactions with a co-worker or employee.

Listen

It is important to actively inquire in situations where it is safe to do so (when a woman is on her own and in private). Be confident and comfortable asking questions about family violence and respect the woman's wishes and decisions. Actively listen, including paying attention to body language. The doctor can, through empathy, demonstrate understanding of how the woman feels.

Inquire about needs and concerns

This process can enhance the woman's control over all decisions relating to her

Box 1. May's story

May* first came in contact with the police when she called to ask them to stop her boyfriend, Troy*, from assaulting her and damaging her property. When the police arrived, May was concerned her boyfriend would be charged with a criminal offence and did not assist with their enquiries. The police then applied for family violence intervention orders for both May and her boyfriend and they were advised of the upcoming court date.

An intervention order is made if the Court is satisfied, on the balance of probabilities, the respondent has committed family violence against the affected family member and is likely to continue to do so or do so again. The conditions of an intervention order can be broad or narrow. Breach of an intervention order is a criminal offence and the penalty for a breach can be imprisonment, a fine or both.

Because neither May nor Troy wanted intervention orders to be made, they did not attend Court and interim orders were made that prevented May and Troy from contacting or seeing each other. May and Troy still wanted to be together and they arranged to meet up. During the meeting they had another argument and Troy was concerned that May would report him to the police and he would be charged with breaching the intervention order, so he went to the police and made a false report that May had slapped him when they had met.

As a result of this false report, May was charged with assault and they were both charged with breaching court orders. May and Troy both still had limited intervention orders protecting them from each other, but these had now been revised so they could continue to communicate. The day before May was due to go to court in relation to the criminal charges, May saw a lawyer from IMCL at RWH. May had just given birth to a daughter and was now engaged to Troy. Troy had stopped drinking and they were attending couples counselling.

IMCL helped May to adjourn her matter and then started to negotiate with the police on her behalf. IMCL argued that the issuing of intervention orders for both parties against each other by Victoria Police is in breach of their Code of Practice for the Investigation of Family Violence and, on this basis, IMCL requested that the charges be withdrawn. By this stage, Troy had been charged with assault and property damage from the initial night when May called the police. Troy had also made a statement of no complaint regarding the false report he had made to the police about May slapping him.

After IMCL negotiating and attending court on May's behalf, both charges against her were withdrawn. This means that May does not have a criminal record and will not face any problems in the future in gaining employment or travelling overseas.

*Names have been changed.

care. The healthcare professional should outline the limits of confidentiality – for example, in situations where children are at risk.[14]

Validate

It is important to provide a response that is both supportive and educative. Part of this is emphasising that she is not to blame for the situation of violence that she finds herself in.

Enhance safety

The first step is to assess immediate risk. Engage the woman in developing a plan to protect herself from further harm if violence reoccurs. Connect (with consent) women in crisis or in fear of their lives to specialist family violence services. The doctor should document interactions and safety plans.

Support

Refer (with the woman's consent) her to specialist support services such as: psychologist, crisis centres, social worker and legal services. The doctor should document this referral.

Conclusion

Domestic violence has a significant impact on women. It may be an issue for our patients, our colleagues or our co-workers. Responses for our patients include integrating legal services into the medical care setting.

Healthcare professionals and lawyers can make powerful allies with significant political clout when they have a common purpose. The collaborative Health Justice Partnerships make good sense for improving the health and working lives of our patients. In order to best target our resources, good-quality research in this area needs to be encouraged.

Acknowledgements

The authors would like to thank 'May' and 'Olivia' for their consent to publish their stories and Prof Kelsey Hegarty for her advice. Finally, thank you to Ms Anne Dive (social worker FMU) for inspiring Dr Woodrow to write the article on domestic violence and HJPs for her medical colleagues.

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Box 2. Dr Olivia's story

My only experience with violence was at a particularly vulnerable time of my intern year when I was making a career choice to step into obstetrics and gynaecology training. The perpetrator, sadly, was none other than my own husband, the one person I should have been able to trust fully. It started off in small ways as passive aggression at first, then expressions of uncontrollable rage, belittling words about my long hours or extreme tiredness on occasion. This quickly progressed to rough handling, often knocking me around. With time, threatening me with sharp weapons became commonplace and I became terrified to share a home with him.

I felt too ashamed to talk to anyone about it at work and did not engage in any work-related social occasions for fear that others would see my cuts. I became very good at covering up his behaviour with excuses to my family as well. My personality changed, I avoided friends; my work suffered, I could not concentrate and every sign of patient distress would dissolve me into tears as my own tears were always very close to the surface. My husband never came to my work or harassed me in the workplace. He always picked me up in the car after work though. My self-esteem was at its worst and I could not see any future beyond my sad life.

As I transitioned from internship into a resident obstetrics rotation, I found great joy in what I did on one hand, but the rapidly deteriorating home situation came to a head, making me need to pull away from work for a period of time. It was a very difficult time as I finally faced up to the increasingly violent behaviour from my husband and made the hard decision to quit the marriage. I was very concerned about a disruption in my career, particularly how the gap would be viewed in my curriculum vitae. I considered my legal options, including an intervention order, but instead one day went to my parents' house and finally told them the whole story. I never went back to the house I had shared with my husband.

My family was very supportive, their love was unconditional and they helped me to see a future. I took an extended period of leave from work during that time and moved away, leaving all my familiar surroundings. Serendipitously, my travels found me working in an unaccredited job in obstetrics. Instinctively, I knew then this was what I would do for the rest of my life. I got a fresh lease of life in this new world; I found new purpose, which helped heal many of the recent wounds. As the months rolled by, I could not stop learning and every day had again begun to be joyful for me. I decided to enrol in a new research study in obstetrics overseas in this unexpected gap year. I finally had something to look forward to beyond this failed marriage. Slowly my personality and confidence returned, I came back to my hometown and applied into RANZCOG training, knowing that I had a purpose and a destination.

As I write this today, I still carry a few visible physical scars, but they are more a show of strength for me now, as I know that the bully is the coward. I have been fortunate that I did not become embittered, or fearful for the rest of my life as a result of those difficult experiences. I am a consultant obstetrician and doing what I have always wanted to do. Joy, compassion and self-confidence are mine again. My career in obstetrics saved me and restored me.

Olivia is a pseudonym.

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Reproductive healthcare for women in immigration detention centres

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According to the United Nations High Commission for Refugees (UNHCR), there are 13 million refugees globally, 10 million stateless people and, by mid-2014, 1.2 million people were seeking asylum.[1] In the global context, the Oceania region has relatively small numbers of refugees and asylum seekers.[2] In Australia, it is difficult to elucidate exact numbers of resident refugees, although the numbers of those currently in community detention, immigration detention centres or regional processing centres is published by the Australian Government.

Currently, there are 1914 asylum seekers in immigration detention centres, either on the Australian mainland or on Christmas Island. A further 2091 people are living in the community after being approved for residence determination and 27 675 are doing so on bridging visas. There are 1648 individuals in regional processing centres, either on Manus Island or the Republic of Nauru. Only men are held on Manus Island while out of the 469 people in detention on Nauru, 113 are women and 95 are children.[3]

In terms of definitions, asylum seekers are defined as individuals who have sought international protection and whose claims for refugee status have not yet been determined.[4] The individuals within immigration detention centres and regional processing centres are almost universally seeking asylum and are therefore not yet technically refugees.

The human rights of asylum seekers under the care of the Australian Government, particularly those of asylum seekers in regional processing centres, has been the focus of intense media and public scrutiny. Reproductive health has been formally recognised as a human right for the past 20 years and, like all other human rights, it applies to refugees and asylum seekers regardless of whether they reside in the community or are detained in a processing centre. To realise this right, these people must have access to comprehensive reproductive health information and services such that they are free to make informed choices about their health and wellbeing. These services have been defined by the Inter-agency Working Group on Reproductive Health in Crises (see Box 1).

Management of pre-existing issues

Many of the following issues vary depending upon the origin of the asylum seeker and the route and conditions they have experienced before their presentation to health services. Hence, the following paragraphs are general and global in nature and may not be representative of all the cohorts in immigration detention and regional processing centres managed by the Australian Government.

As with most socially disadvantaged groups, asylum seekers may be at a higher risk of chronic illnesses, infectious diseases, mental illness and prior gender-based violence. Many, but not all, of these women are from populations that experience low nutritional status, endemic infectious diseases (such as malaria or HIV) and poor access to healthcare facilities. Some will also be fleeing conflict zones where sexual violence was commonplace.

The effect of the situation that leads to becoming a refugee (be it war, disaster or persecution) on an individual depends upon their capacity to withstand complex social, political and economic changes. As an individual's resilience to manage

Box 1. Reproductive health services required for human rights

- family planning, counselling, information, education, communication and services;
- education and services for prenatal care, safe delivery and postnatal care, and infant and women's healthcare;
- prevention and appropriate treatment of infertility;
- prevention of abortion and the management of the consequences of abortion;
- treatment of reproductive tract infections, sexually transmitted diseases, including HIV/AIDS;
- prevention, early detection and treatment of breast cancer and cancers of the reproductive system and other reproductive health conditions; and
- active discouragement of harmful traditional practices, such as female genital mutilation.[5]

these changes decreases, their vulnerability to detriment increases. Hence, the most vulnerable are at the most risk.

While women are not an intrinsically vulnerable group, there is a potential for increased vulnerability as in some societies women continue to hold low social status or are the targets for acts of violence. Paired with the loss of normal social and family structures this often removes established coping strategies and supports. This potential for increased vulnerability is often reflected in reproductive health outcomes during displacement, placing refugee and asylum seeker women in a high-risk group for adverse outcomes. This has been recognised recently and data collected by the National Maternal Death Reporting form have been amended to include this information.[6]

Initial assessment of these women involves screening for and managing pre-existing conditions. The exact regime will depend upon their country of origin and the countries through which their transit to Australia occurred (see Box 2).

Management of issues in detention

Access to healthcare

While healthcare is easily accessible within immigration detention centres run by the Australian Government, access to healthcare is a complex issue within immigration detention centres globally. In other countries, it has been documented that women, especially pregnant women, held in immigration detention centres have poor access to medical care.[7] For women in immigration detention centres or regional processing centres, the only way they can access reproductive healthcare services is through the sole provider of medical services in these centres. While all of these services are offered, they require culturally appropriate education to inform detainees of their availability. It is also important that these services are seen to be independent from government immigration services. The incorrect perception of a lack of confidentiality may cause fear that accessing medical services could adversely affect refugee status determinations. This incorrect perception could potentially act as a barrier to accessing reproductive healthcare services within the detention or processing centres. Similarly, in some cases, asylum seekers seek to positively affect refugee determinations or location of detention by using specific medical conditions.

Remoteness

One of the immigration detention centres and both of the regional processing centres are in remote locations and therefore available medical services are akin to those accessible in rural or remote Australia. This means that some gynaecological surgical services, services for the care of severely preterm infants and complex obstetric services require transfer to facilities in major cities. An effective system to facilitate timely transfer is important, as a significant proportion of displaced women will encounter a potentially life-threatening obstetric complication.[8]

Mental health

Mental health is an important issue for those in detention centres and regional processing centres and much has been published on this issue, particularly the mental health of men and children in detention. While exact figures are difficult to ascertain, a significant proportion of detainees receive a mental health diagnosis.[9] There is a recognised association of antenatal depression with miscarriage, preterm labour and low birthweight. Postnatal depression also has important effects on bonding and attachment, with potential deleterious effects on the mental and physical development of the child.

Clearly, the provision of adequate mental health services, as an adjunct to reproductive health services, is crucial, particularly during the provision of antenatal and postnatal care. These services are universally provided within immigration centres and regional processing centres run by the Australian Government.

Antenatal services on Nauru

As part of a group of obstetricians, I am involved in providing an antenatal service to asylum seekers in the regional processing centre on Nauru. Within the limits of working within the centre, we aim to deliver antenatal care equivalent to that available on the Australian mainland.

Maternity care is provided from the diagnosis of pregnancy until a six-week postnatal check. This includes the delivery of routine assessments, pathology, imaging and referrals as per the existing Australian standards. At a practical level, this care is delivered via monthly appointments with subspecialist or specialist obstetricians as well as by midwives or general practitioners. Mental health services are also provided to all antenatal and postnatal patients within the immigration detention centres and regional processing centres.

Given that these women are asylum seekers and mindful of the well-documented effects of the detention centre setting, all are treated as 'high risk' patients.[9] Therefore, specialist sonographers perform an obstetric ultrasound at every visit in addition to the routine ultrasounds for the combined first trimester screen and the fetal morphology

Box 2. Initial assessment

- Health induction assessment upon arrival into detention*:
  - Public health screening questionnaire
  - Screening for infection:
    - Chest x-ray
    - Hepatitis B, hepatitis C, HIV and syphilis serology
  - Mental health screen
  - Full assessment by general practitioner, including additional investigations where necessary
- Additional assessment after diagnosis of pregnancy:
  - Assessment of nutritional status:
    - Body mass index, micronutrient deficiencies such as iron, folate, iodine, vitamin B12 and vitamin D
  - Mental health screen
    - Including opportunities for safe and sensitive discussion of gender based violence.
  - Female genital mutilation, where relevant

* Health induction assessment currently used by International Health and Medical Services

assessment. This is done in concert with their antenatal appointments.

Non-invasive prenatal testing has also been made available to the detainees. All consultations are done with a gender-appropriate interpreter facilitating communication and explanation. This specialist care complements the primary care delivered by resident general practitioners, midwives and nurses. Mental health support is readily accessible for all patients, especially during pregnancy and the postnatal period.

Owing to the remoteness of the facilities on Nauru, currently all antenatal patients are transferred for labour and delivery. This translates to transfer at 28 weeks for those women in the regional processing centre on Nauru. This occurs due to a lack of permanent obstetric and neonatal services on Nauru and this policy may change in the future once appropriate services are established. Transfers occur earlier for those that require emergency care or who have higher risk pregnancies.

Limited gynaecological services are also available. During our monthly visits to Nauru, women referred for gynaecological review are also seen. While assessment, including ultrasonographic imaging and basic medical management, is available, surgical interventions are limited by the available facilities and the remoteness of the processing centre and often require further referral to a mainland service. Again, this may change once appropriate services are established on Nauru.

The ethics of providing care

No discussion of the provision of healthcare to patients within immigration detention centres or regional processing centres would be complete without considering the ethical aspects of this practice. There has been commentary regarding the ethical challenges for doctors working in the immigration detention system, with some authors suggesting that doctors should boycott the provision of services in immigration detention centres and regional processing centres.[10] This has been the focus of renewed attention now that the Australian Parliament has passed the Australian Border Force Act 2015.

Some claim that this Act means that doctors and teachers working in immigration detention facilities could face up to two years in prison if they speak out against conditions in the centres or provide information to journalists. If this were correct this could potentially leave doctors in a difficult moral situation and may impair their ability to provide broader, public health type advocacy on behalf of detainees.

Recent media statements by the Department of Immigration and Border Protection have countered these claims and reinforced that medical professionals, teachers and other professionals employed by and on behalf of the Department of Immigration and Border Protection are not inhibited from reporting matters in line with their professional obligations. The same media statement stated that claims that the provisions of the Border Force Act would prevent reporting or scrutiny of conditions in immigration detention were misleading.[11] It remains to be seen what impact, if any, this new legislation will have upon the delivery of care within Australian immigration detention centres and regional processing centres.

Conclusion

The provision of care to asylum seekers within detention centres and regional processing centres is complex, both owing to the intrinsic vulnerability of this population and because of the environment in which the care is delivered. Ethical challenges add another dimension to care delivery in this complex, highly politicised environment.

Despite these challenges, care within detention centres continues to be provided with care and compassion, and at a standard consistent with the healthcare afforded to others within Australia.

Disclosure of interests

I am employed by Arrivals Obstetric Centre who are contracted by International Health and Medical Services to provide obstetric and gynaecological services to asylum seekers in the Nauru regional processing centre.

Acknowledgment

Obstetric and gynaecological services to asylum seekers in the Nauru regional processing centre are also provided by Dr Paul Bretz, A/Prof Greg Duncombe, Dr Megan Castner and Dr David Watson. I would like to thank them for their editorial advice and support.

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Meeting the medical needs of refugees and women seeking asylum

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Coming to a new country demands the willing surrender of a life well understood. To choose instead to embrace the unknown – the unknowable – and place at stake one's future and one's children's future, on the hope of one singular venture. It requires the recreation of a person's very identity – to become a mixture of something old and something unfamiliar – the only certainty is that you can never be the same as that person who would have stayed behind. It necessitates learning to accept of a wave of change: to familiar traditions, boundaries and expectations. To migrate is to let go and to fall through the looking glass, to embark upon an alternative life in which each quotidian act becomes a contest of patience and will.

Australia is a nation of over 300 languages. One-in-four Australians were born overseas and 60 per cent of Australia's future population growth will come from migration. More than a million Australians have migrated here in the past five years. On top of this, nearly 1.7 million people are currently living and working here temporarily.[1] Equally, as our population has rapidly diversified, the number of patients who do not speak English well or at all has grown dramatically.[2] For the medical profession, the proliferation of complex cultural cases presents rising and unprecedented demands on time and resources.

Compared to Australian-born women, migrant and refugee women from non-English-speaking backgrounds experience higher rates of illness and health disadvantages. After living in Australia for five years, the average health of many migrant and refugee women has declined, despite increases in the general standard of living[3]; suggesting that access to care is a key factor. Furthermore, migrant and refugee women are under represented in use of preventative health services and over represented in the acute and crisis setting. A lack of health system literacy and knowledge of how to navigate Western consumer-model health services sharply limits the access of a growing number of new Australians.

Lack of access is compounded by gender inequality. Increasingly, our migration program sources from countries with very different norms with regard to the role of women and their place in society. Domestic violence rates among immigrant communities are higher than the national average while, of concern, the reporting rates are significantly lower. Across every indicator of gender equality, migrant women are losing out: their participation in the workforce is well below migrant men, English language acquisition is lower and literacy and access to education is lower still.

> 'To migrate is to let go and to fall through the looking glass, to embark upon an alternative life in which each quotidian act becomes a contest of patience and will.'

The inequality facing refugee women, in particular, is further exacerbated by their pre-migration experience. Many have fled places of conflict, where rape, sexual torture and slavery are used as weapons of war. Rates of sexual violence are rampant in refugee camps, leading to downstream sexual and reproductive health issues including increased risk of sexually transmitted infections, pregnancy and birth complications, and mental health consequences of trauma. Women from refugee backgrounds coming to Australia will often have no prior experience of Western medicine or Western birthing and antenatal practices and may find the

Getting prepared for birth can be complicated when you are in an unfamiliar environment.

application of technology and birthing interventions confronting.

For practitioners, three key issues need to be kept in mind when treating women from migrant and refugee backgrounds: language, culture and gender dynamics.

As an illustrative case study, Aditi*, a recent migrant from India, was brought over on a spouse visa to honour an arranged marriage. Her prospective husband had already been living in Australia for ten years, having originally arrived on a student visa. Aditi had no English and very little formal education. Her family had struggled to bring together an appropriate dowry, complicating her marriage from the beginning. Subsequently, her husband and her in-laws began to harass her in order to extort an increased dowry. The form of this harassment included repeated physical abuse from her husband and psychological abuse from her sister in-law.

After a year she fell pregnant and saw the child as a blessing. Aditi hoped the child would help mend her troubled relationship and would bring some joy to her life. She wanted her children to grow up in a country able to provide the privilege of the education she had not herself received. When she told her husband of the news he beat her and demanded she undergo termination of pregnancy. Her friends advised her that Australia is not like India; if she told the doctor that she wanted to keep the child, they would not perform the termination.

Her husband escorted her to the pre-termination counselling session. When the doctor called her in, her husband stepped forward and stated he would translate for her. She sat in the room with tears flowing down her cheeks as her husband explained that she was upset because she did not want to be pregnant and that she wanted the baby gone immediately. The doctor engaged only with her husband. Aditi explained later that she had felt more powerless in that moment than she ever felt before in her life. She said in that moment she gave up hoping for herself and began to believe that everyone in this new world was on her husband's side.

While Aditi's story is one isolated experience, it demonstrates the problems and complexities that doctors face. From a practitioner's perspective on the encounter, arranging to have a neutral interpreter in the room or being able to understand the background cultural dynamics in play are both significant hurdles to remedy, requiring further resources that are often simply not available. Simply put, Australia's broader framework of healthcare delivery – encompassing everything from referral pathways and Medicare claims to continuing education and auxiliary services – has not kept pace with our changing demographics. All the while,

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While an intern, I researched working in Africa, but was always asked if I was a specialist or had management skills or spoke another language. In the end, I gave up on the idea. I continued doing another two years residency, with 12 months of that focusing on obstetrics and gynaecology, and achieved my DRANZCOG in 1984. I then started working at family planning and general practice, eventually co-owning a general practice of seven female doctors with three female colleagues. I also worked three days a month in country South Australia as part of the Federal Government's Rural Women's GP service in 2002. Hearing about the poor status of women's health in developing countries reignited my desire to focus some of my energies on improving this situation. I decided on two specific responses: I would endeavour to work in the field, but also put together a birthing kit that would be useful for mothers.

Working in the field

To prepare, I sold my share of the medical practice, did country work and brushed up on my French language skills. When offered a position with Medicins Sans Frontieres for six months in 2003–04, working with Afghan refugees in Masshad, Eastern Iran, I accepted.

Free health clinic services, medication and, if required, hospital treatment were provided to those refugees without means. Usually, 100–120 clients were seen by three to four doctors each four-hour session. Services were provided in a fixed clinic in Gulshar and mobile clinics temporarily set up in mosques or uninhabited houses.

I required an interpreter, Neshat, when interacting with patients, but luckily all the medical staff wrote their notes and spoke to me in English. I supported the midwife who provided antenatal care to patients. Bloods or other tests were performed infrequently. No smears were done and breast checks only if lumps were noted. During the six-month placement, I learned Farsi up to a grade 3 literacy level.

When I returned to Adelaide I commenced work as a locum. One of my first locums was with the Migrant Health Service in Adelaide where they provide comprehensive health assessments for new arrival refugees. The six months in Iran provided me with insights into the issues and realities that many of the

The author on placement in Iran.

the consequences of overlooking cultural complexity upon safe and effective patient care have become too grave and too common to be ignored.

What can practitioners do?
Firstly, be mindful not to make assumptions. Speak to the patient, as their cultural background may or may not inform their personal beliefs and expectations. Particularly around childbirth and women's health, a medicalised Western approach may be very unfamiliar. Furthermore, what may seem banal in terms of sensible health advice can conflict with cultural understanding, thus be difficult to follow or be misinterpreted. For example, it is not uncommon in certain communities to interpret medical complications, such as gestational diabetes, as a bad spiritual omen or curse. Be mindful of the presence and influence of other family members, including partners, and use judgment and intuition. It is easier to call family members

A new mother welcomes her baby.

refugees had experienced. Many women refugees arrived under the 204 visa category. This is the women-at-risk group, which often covers women who are head of households or widows and their families.

The groups I worked with were initially from Yugoslavia then from Sudan/Democratic Republic of Congo, then Iraq and Afghanistan. Now there are more Bhutanese and Burmese refugees, plus asylum seekers, many of whom are currently in community detention.

I have now spent 11 years working with refugees and asylum seekers, including stints in detention centres in Darwin and Christmas Island. Often they have higher incidences of health issues not commonly seen in Australian general practice. African refugees experienced conditions such as schistosomiasis, malaria and sickle cell anaemia. Middle Eastern women had more issues to do with chronic body pains and low vitamin D. Post-traumatic stress disorder is a common experience for people with refugee backgrounds. I have also seen cases of TB, leishmaniasis and scurvy in Adelaide. I often spend time writing support letters, filling out official documents and being an advocate as well as educating on basic health issues. Many women have their first ever smears in the Well Women's health clinic. They have access to good-quality antenatal and delivery facilities within our hospitals here. They often comment on how polite and respectful health staff are and that they explain things to them.

A small birth kit can make a big difference.

Birthing kits
In the late 1990s, I helped create a small one-use birthing kit that allows women in rural and remote areas of resource-poor communities to access items that ensure a clean and safe birthing environment. The kit contains a square metre of plastic, soap, a pair of gloves, pieces of string, a scalpel blade and gauze within a clip-lock plastic bag. It weighs less than 100g. The kits were originally financed, collated and sent by Zonta International clubs within the three Australian Districts 22, 23 and 24. Zonta International is a women's service organisation, empowering women through service and advocacy. In 2006, the Birthing Kit Foundation Australia (BKFA) was formed to continue the work. I have been a board member since its inception. BKFA has provided 1.4 million kits free, mainly to non-governmental organisations that work with mothers in 28 countries. It has arranged for many more kits to be produced in the country. BKFA has also trained 9000 birthing attendants in Vietnam, the Democratic Republic of Congo, Ethiopia and India. In the last 12 months, BKFA has also organised three train the trainer programs in the Democratic Republic of Congo and India to increase the reach of education.

The knowledge I acquired doing obstetrics and gynaecology has been vital in performing my medical role. I, like many professionals working in health areas, hope to support people, especially women, in whatever way I am able, to achieve their optimal health and a full life.

A pregnant woman in her village – becoming a migrant means leaving many cultural certainties behind.

back into the room once you have determined their presence accords with your patient's wishes.

Secondly, champion systems to identify who will need an interpreter ahead of time. In the public system, this may mean advocating for internal change. Raising demand from practitioners to improve the identification of patient language needs and provision of organisational resources for trained interpreters is a good start. In private practice, ensure your booking staff make note of a patient's language skills, are able to assess if an interpreter may be required and, if needed, know how to arrange interpreter sessions. If the patient does not speak English, allow for extra time for the consultation.

Thirdly, when appropriate, involve migrant support services. There is a network of many settlement service providers around Australia with caseworkers trained to deal with cultural complexities. Not all migrants are eligible, but many of the most vulnerable and newly arrived patients are. Caseworkers themselves can offer independent support – they can chaperone clients to appointments, follow up dietary requirements, assist in filling prescriptions, monitor patient progress and advocate on their behalf. Not withstanding the limitations of patient confidentiality, settlement services bring dedicated cultural liaison skills to the table, and will be familiar with the process of arranging an interpreter on the patient's behalf. The Settlement Council of Australia can provide details of your local settlement provider (www.scoa.org.au).

> 'To place their trust in you at a moment of the greatest vulnerability, where not only their life, but also their child's life is in your hands is an act of great bravery.'

Finally, seek to learn about unfamiliar cultures as both a professional and personal interest. The better you understand your patients and their backgrounds, the more you will hear in their story, the better the questions you will ask and the stronger the chance you will have in your words being listened to and affecting change. If you are aware of a substantial representation of a particularly ethnicity in your community or clinic, take the time to get to know about the country and culture. It is an investment that will return tenfold in terms of improvement in patient relationships and patient care.

Obstetricians and gynecologists see women at a point of profound emotional vulnerability – fertility treatment, pregnancy, labour, menopause or an abnormal Pap smear. To imagine a woman seeking help in a foreign country, with no comprehension of what is being said, with no knowledge of the procedures, the machines or the tests to be run, lets us understand her personal ordeal as all the more daunting.

To be a migrant is to wear a badge of courage. We routinely trust our lives

to doctors in an act of faith. For many migrants there is no such preconceived social conditioning – they have not grown up enduring dozens of visits to GPs for sore throats and sick notes or watched countless re-runs of ER. They have not lived in a culture where reverence to white coats and stethoscopes is the norm. To place their trust in you at a moment of the greatest vulnerability, where not only their life, but also their child's life is in your hands is an act of great bravery. To spend a little more time and summon a little more patience is a small appeal in return.

*Name changed to protect identity. This interview was conducted on 25 May 2015.

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Ensuring the future of GP obstetrics in rural Victoria

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A state-wide training and support program for DRANZCOG Advanced rural general practitioners is helping to ensure the future of GP obstetrics in rural Victoria. The program, which includes practical workshops, evening dinners and networking opportunities, was established to fill a gap in current DRANZCOG training.

The deficit was identified by previous rural GP DRANZCOG trainees, who reported a lack of confidence in their competence to practice as GP obstetricians (GPOs), and feelings of professional isolation. Concerns this could lead to declining numbers of GPOs and threaten the viability of rural maternity services prompted the establishment of the DRANZCOG trainee training and support program.

The program is co-ordinated by Southern General Practice Training (one of the Victorian Regional Training Providers of the Australian General Practice Training Program and the Rural Generalist Program) and funded by the Victorian Government Department of Health. Now in its third year, the program is delivered by a group of dedicated specialists and GP obstetricians and is open to rural DRANZCOG trainees, as well as GPOs from smaller hospitals across Victoria.

The program recognises the vital role GPOs play in providing clinical services and support to women at all stages of their pregnancy and birth, particularly in rural areas where specialist obstetric services may be limited. A decline in the number of practising GPOs, especially those with caesarean skills, would have a significant impact in rural Victoria by placing increased pressure on specialist obstetricians at larger regional clinics and hospitals, and increasing the likelihood of women having to travel out of their community to give birth.

The program

The State-wide Training and Support for DRANZCOG Advanced Rural General Practitioners program aims to encourage and further increase the capacity of Victorian trainees to practice rural GP obstetrics in the future.

Its expected outcomes are:

- clinical, professional and collegiate support for rural generalist GPs;
- competent and confident rural generalist GPs; and
- acquisition of the required procedural competencies for rural generalist GPs.

The program consists of practical, hands-on, skills-based workshops delivered over one-and-a-half days, four times a year in varying regional locations across the state.

Groups are kept small, with about ten trainees in each session, to enable participants to practice vital skills in a safe space, with time to ask questions, practice techniques and share experiences with peers and mentors.

Skills-based learning areas covered by the program include:

- surgical skills necessary for caesarean section – anatomy, knots, simulation, complications;
- the RANZCOG Fetal Surveillance Education program;
- IUD use and practical insertion training;
- operative vaginal birth, including vacuum and forceps;
- perineal repair, including third-degree tear workshop;
- episiotomy;
- obstetric emergencies, including PPH, breech, manual removal, shoulder dystocia;
- anaesthetic and ethical issues in obstetrics;
- medical termination of pregnancy;
- perinatal mental health and intimate partner violence counselling;
- communication skills including breaking bad news and the difficult patient; and
- simulation workshops, including team building and crisis resource management.

The topics covered at each workshop differ, so trainees are encouraged to attend all four throughout the year. While the focus of the workshops is on skill development and consolidation, the residential nature of the program also provides mentoring and networking opportunities to reduce

feelings of professional isolation and help develop a support system of trainees, GP generalists and specialists.

The burden of travel is reduced by the provision of accommodation and evening social events foster collegiality. Peer networking then continues through regular email communication between workshops.

A similar state-wide training and support program is run in Victoria for GP anaesthetists and, given the relationship between the two specialities, two of the GP obstetric workshops per year are co-located with the anaesthetist program. While most of the sessions run concurrently, some joint sessions are attended by both sets of trainees, further enhancing the networking aspect of the program.

The state-wide training and support program expands on and complements the successful Post-DRANZCOG pathway[1] program operating in the Gippsland region, which also addresses issues of confidence and competence by providing support to GPOs on completion of their DRANZCOG Advanced qualification.

The results

An evaluation report produced by the Monash School of Rural Health, Office of Research at the conclusion of the first year of the program in 2013, found it had been very successful in achieving its expected outcomes.[2]

The report found the program substantially improved:

- the self-reported procedural and professional competence of participants;
- capacity to practice rural GP obstetrics in the future;
- the translation of evidence into practice by trainees; and
- development of a supportive, collegial community environment that helps overcome professional and geographical isolation.[2]

Participants indicated the most valuable aspects of the program were: it was relevant, stimulated interest in the topic area, was practical, hands on, reduced the sense of isolation through participation, and enhanced their capacity to integrate theory and evidence into practice.[2]

Direct feedback from participants about the program, via written evaluation surveys at the end of each workshop, has also been overwhelmingly positive.

Participants have praised the program's practical and clinical focus, with direct quotes from evaluations stating:

- 'It was comprehensive, covering highly relevant topics for my stage of learning. Opportunities were provided that simply aren't available in the workplace.'
- '[It provided] instruction and practical clinical skills in a non-threatening environment with good feedback.'
- '[It was] practical. [I have] increased confidence to attempt instrumental deliveries and complex tears.'[3]

In addition to the skills learned and theory discussed, participants also highlighted the mentoring and development of a support network of trainees, GP generalists and specialists as a critical benefit of attending the program.

The future

Victorian Government funding is allowing Southern GP Training (SGPT) to again deliver four one-and-a-half day workshops as part of the State-wide Training and Support for DRANZCOG Advanced Rural General Practitioners program in 2015.

Workshops in Gippsland, Bendigo and Colac have already been held, while workshops in Wangaratta will take place in October. The Gippsland and Colac workshops targeted GPOs only, while the workshops in Bendigo and Wangaratta combine with anaesthetist registrars.

Based on the proven success of the program to build confidence, competence and enthusiasm among DRANZCOG Advanced rural GPs, it is our sincere hope government funding will continue into the future, allowing the vital work of GPOs in rural Victoria to not only survive, but thrive.

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Box 1. Case study – Ruyu Yao, GP registrar and advanced DRANZCOG trainee, Gippsland

Inspired by the good work of the Gippsland GP obstetricians and the local specialist obstetrician/supervisor Dr David Simon, I embarked on the challenging and rewarding journey of DRANZCOG training in 2011, at Latrobe Regional Hospital, then went on to Advanced Diploma training at West Gippsland Hospital in 2014.

I was well supported by the supervisors, with plenty of hands-on experience, lots of formal and informal discussions, encouragement and honest feedback.

I participated in the SGPT State-Wide Training and Support DRANZCOG workshop program in 2014, where I received further skills training and was provided with excellent opportunities to exchange clinical experiences with colleagues and network with other trainees, GP obstetricians and GP anaesthetists. We were given the opportunity to discuss concerns and issues we may have with the working arrangements in different hospital settings, which proved extremely helpful, and the training was flexible enough to still allow me to undertake locum work in the Northern Territory during the year.

I am now in the final stage of my GP training and am sharing in the antenatal, intrapartum, and postpartum care of patients with other local GP obstetricians. I'm very fortunate to have a great team giving me ongoing support both at work and in my social life, and I highly recommend participation in the SGPT training program to other DRANZCOG Advanced rural GPs.

A letter from the country

PAR AVION
BY AIR MAIL

SOUTH WEST GYNAECOLOGY

Locked Bag No. 12
Bunbury. W.A. 6231

Locum:-
Dr D.P. Mohen MB, BS(WA), B MedSci FRANZCOG
Specialist Obstetrician and Gynaecologist

Dear Patrick,

It was wonderful to hear from you after so long. What have we been up to since leaving Felixstowe on a frosty autumn morning in 1996? Since returning to Western Australia (WA) with RACOG Fellowship hot in hand, I have been based in Bunbury, the largest regional centre in Western Australia, working as a consultant obstetrician and gynaecologist. For 15 years I was a member of a private group practice and, in more recent years, my clinical work has continued as a locum specialist, some sessional work at the local regional hospital and periodic outreach clinics to remote communities. During a stint as a RANZCOG Councillor, representing Provincial Fellows, I developed an interest in the challenges associated with health service provision in general, and maternity services in particular, across the widely scattered rural communities of the large regional expanses of Australia. This interest has been further nurtured through two part-time obstetrics and gynaecology clinical support roles – one with the state's tertiary women's health service and another with WA Country Health Service, which supports public health services in regional WA.

The outreach clinics and clinical support positions have seen me travel widely through the outback, with the opportunity to visit some very interesting places and to appreciate some of the challenges faced by healthcare workers who choose to live beyond the boundaries of large cities and towns. Christmas Island (CI) is an ecological treasure trove – the memory of sharing a resort swimming pool with diving frigate birds is a favourite recollection from outreach clinic visits to this very isolated Australia territory. For the two district medical officers manning the CI health service, emergency evacuation of ill patients requires a charter aircraft from the Australian mainland more than 2000km away. Healthcare workers in such settings must be resilient and resourceful clinicians.

What makes for a good life as a rural obstetrician and gynaecologist? From a work perspective: great office managers and staff to minimise the stresses associated with the irksome tasks of business and practice management, congenial specialist colleagues who both support and continue to challenge our rural team to keep up with or ahead of our city colleagues. Should I mention the near mutiny precipitating practice computerisation project? We all survived – just – and now wonder how we managed without. Will the dinosaur-like public hospital recordkeeping system ever catch up? Of all the practice changes I have seen in the last 30 years, computerisation of records is one of the most significant patient safety measures I have witnessed. No more illegible prescriptions or case notes. Rural practice provides opportunity to maintain a broad general specialist clinical practice: the six-year training commitment still feels like it was all worthwhile. Maintaining links with subspecialists in the city is an important sanity-preserving strategy.

This is me, Ashton and our dog Henry with KCV, the plane that Ashton built.

The professional downsides? For all the joys of seeing a family welcome a newborn child, the heartache of a stillborn baby always weighs heavy. Living in smaller communities can magnify the personal-professional impact of such events. On-call rosters can be wearing with small on-call teams. Skilled midwives and first on-call GP obstetricians and registrar teams help specialist teams survive as regional centres grow in size and, consequently, clinical workload.

One aspect of medicine I have always found challenging is a capacity to 'switch off' from work. A couple of years into our life in Bunbury I found an avenue – an unexpected spin off of Ashton's lifelong interest in aviation. The local airfield is not far from our Bunbury home (an advantage of rural life: nowhere around town is very far away) and many hours were soon spent at the aeroclub. With Ashton's encouragement, having finally recovered from the trauma of Fellowship examination and with a mindset that I would never sit another examination of any sort, I decided to pursue a private pilot's license. There is nothing that concentrates the mind more on the task in hand than sitting in a heavier-than-air machine at 1000 feet above ground level knowing that it is only going to stay up if you keep your wits about you and make the right moves at the right time. There is no room for ruminations over work.

If you visit our Bunbury home you will see my grandmother's hatstand as you enter our front door: it is covered with different hats for all occasions: it reflects my working life – different hats for different roles and I enjoy wearing them all. I have been very lucky to live in a great part of the world with wonderfully supportive colleagues. Would I recommend rural obstetric and gynaecology practice in Australia as a career to which your daughter might aspire: absolutely! Looking forward to seeing you again.

Best wishes,

Diane Mohen

Life at sea: practising medicine in the navy

Dr Elizabeth Rushbrook, CSC
MBBS, MHA, FRACMA
Commodore
Royal Australian Navy
Director General
Navy Health
Director General
Health Capability

I am a Medical Officer in the Royal Australian Navy. As a specialist medical administrator, I currently work within the Department of Defence in two roles: within Joint Health Command as the Director General Health Capability; and within the navy as the Director General of Navy Health Service.

A Queenslander, I started my military career as a third-year medical student. Looking for a way to support myself through medical school in the early years, I was attracted to the Defence Undergraduate Medical Scheme and joining the Navy seemed like the best option for me at the time. I was sponsored through four years of medical school, graduating in 1994. I completed my internship and RMO1 year within Queensland Health before commencing full-time military work in 1997. I had no strong family ties to the military or to medicine, so I had no preconceived ideas as to where medicine or the military might take me. It has been a wild ride.

My early military years were spent based in the Sydney region, initially working from the navy base that supported most east-based ships, then some sea time on a variety of ships. Since then, I have worked from the Sydney establishment that supports mine warfare and clearance diving forces, within the military hospital at Balmoral and from the Nowra Air Station. Almost ten years ago, I was posted to the Canberra area where I have worked in a variety of medical administration roles, both within the navy and within Joint Health Command.

Being posted to sea as a medical officer was always interesting. I don't think I have ever joined a ship where I didn't already know at least ten per cent of the crew. This made joining a new ship easier: shortening the integration time, quickly making it seem like you had been part of the team for months. On a major warship, I normally worked closely with a small team of two navy medics. Navy medics have substantial paramedical and nursing training, and also extended skills in primary healthcare. They normally only have a medical officer join their team when on extended deployment on operations, or when the risk profile of the ship's activities is assessed as requiring medical officer support.

I have so many stories and memories of my time in the navy. Some are sedate, but others are heart-stopping – from an emergency presentation of a member of the Armed Forces for the National Liberation of East Timor (FALINTIL) who was injured by a large, single cut across the throat within a cantonment (in which the FALINTIL were required to remain until peace was restored) on the first day of my short deployment to the UN Military Hospital during the early phases of the peace mission to East Timor in 1999, through to a substantial allergic reaction while at sea, many hours away from an evacuation staging point and even more hours away from an Australian tertiary hospital. I recall many cuts, abrasions, fractures, aches, pains, tumours, joys and tears. The numerous stories are personal and too long to do them justice here.

> 'To participate in active and continuous risk assessment and management of dynamic medical circumstances constantly challenges and rewards me.'

I have never been shy to admit that I don't recall ever having single-handedly 'saved' a person. Any 'save', no matter how small or how big, has always been a team effort. With a good team, focused on the job at hand, the work has always been rewarding. Indeed, the largest part of my job hasn't been the saving, but has always been about preventing and being prepared to save. The importance of comprehensively assessing a member's fitness for duty and workplace restrictions in the context of a seagoing environment cannot be understated. It is this part of my job that has proved the most rewarding over the years. To participate in active and continuous risk assessment and management of dynamic medical circumstances constantly challenges and rewards me. It still makes my day when I am pulled up by a member who reminds me of some advice or assessment I provided many years before that they credit as a key milestone within their career.

It requires hard work and determined focus to build and maintain a service/force that

is always 'prepared' to do the extreme – to take a self-contained health service into an operational zone and provide high-quality, evidence-based care at a moment's notice. This means you always need to be taking stock of the level of staffing, their training, their availability, their medical fitness to deploy; the level of pharmacy and equipment stock – always serviced and ready to go; the serviceability of the facilities and their fixtures and fittings. One deficiency can critically reduce the capability. To this end, we audit, measure, train and exercise in a constant cycle. You always need to be at the top of your game.

Since moving to medical administration, I find I am still able to make a real difference at the coal face: by leading or participating in projects such as developing and implementing recruitment and retention strategies for the health workforce; designing and operationalising health facilities and systems on ships; introducing new health capabilities such as deep frozen blood products; and implementing new health service standards or governance frameworks. I most enjoy providing technical advice; teaching and mentoring; or building collaborative frameworks and networks to focus on and resolve key issues. All of this would not be possible without a supportive team of leaders, peers and subordinates. I find the navy and defence teams are a pleasure to work with.

However, medicine isn't the only part of my life. I have an unhealthy obsession with rugby union and shopping, and continuously torture my friends and family with my desire to master golf, skiing and the guitar. I am currently the President of Navy Rugby Union and when not decked out in the 'Blue', you can usually find me tucked away in the corner enjoying (muttering under my breath from time to time) a game of rugby – be it junior, local or regional, Super Rugby or an international competition.

Finally, I couldn't do any of my work without the support and love of my family. My husband Andrew supports my dreams and work without question and constantly encourages and believes in me; and our beautiful boys, Jordan, William and Thomas, whose antics keep us on our toes every day.

I consider myself privileged to have been given the opportunity to study medicine, join the military and specialise in medical administration. Every day in the office is different and challenging, but I wouldn't change it for the world.

Q&a

For the broader *O&G Magazine* readership, balanced answers to those curly-yet-common questions in obstetrics and gynaecology.

Q *'My patient has requested a permanent sterilisation, but she has been reading about ovarian cancer risks and rather than tubal clips wants me to remove the fallopian tubes instead. What should I do?'*

Dr Stephen Lyons
BSc PhD MBBS FRANZCOG

a The thinking about the aetiology, morphology and behaviour of ovarian cancer has changed dramatically over the last few decades, such that the condition is now considered to be a heterogenous group of diseases.[1,2] Epithelial tumours account for about 90 per cent of ovarian cancers, with the remainder comprised of germ cell and sex cord-stromal tumours. There are five main types of epithelial tumours: high-grade serous carcinoma (HGSC), endometrioid carcinoma, clear cell carcinoma, mucinous carcinoma, and low-grade serous carcinoma with relative frequencies of about 70 per cent, ten per cent, ten per cent, three per cent and less than three per cent, respectively.[3] The BRCA1 and BRCA2 gene mutations were identified in the mid-1990s and have been associated with an increased risk of ovarian cancer and breast cancer. Of particular interest here, the BRCA mutations are associated with HGSC, the commonest sub-type of ovarian cancer, responsible for about 70 per cent of ovarian cancer deaths. In 2001, high-grade serous tubal intraepithelial carcinoma (STIC) was first identified in the fallopian tube fimbria, but not the ovary, of some BRCA-positive patients undergoing risk-reduction bilateral salpingo-oophorectomy.[4] It is now thought that at least 60 per cent of BRCA-positive HGSC is of tubal origin. Bilateral salpingo-oophorectomy performed by the age of 40 years is thought to decrease the risk of ovarian cancer by about 80 per cent in high-risk women. Consistent with a tubal origin for many HGSCs, bilateral salpingectomy without oophorectomy by the age of 40 years in BRCA-positive women also appears to decrease the risk of ovarian cancer, by about 60 per cent.[5] Hence, the benefit of risk-reduction bilateral salpingo-oophorectomy and salpingectomy has been established for women at high-risk for ovarian cancer. What is the situation for BRCA-negative women who are low-risk for the development of ovarian cancer?

The vast majority of HGSC (85–90 per cent) is sporadic; in other words, not BRCA-related. However, high-grade STIC has been identified in the fallopian tubes of BRCA-negative women undergoing salpingectomy performed for benign conditions (usually at hysterectomy), as well as at surgery for HGSC. Indeed, STIC lesions have been identified in the tubal fimbria of up to 60 per cent of a population of women untested for BRCA mutations who have HGSC, the same proportion as for a high-risk population.[6] It is therefore likely that women at low-risk for ovarian cancer may also benefit from opportunistic risk-reduction bilateral salpingectomy. Unfortunately, the available information is generally from cohort and case-control studies and no randomised controlled trial (RCT) data are available. While there is no suggestion that bilateral salpingectomy should be performed routinely in low-risk women to decrease their risk of ovarian cancer, there is a trend towards performing opportunistic bilateral salpingectomy at surgery for benign gynaecological conditions (for example, hysterectomy) to decrease the risk of ovarian cancer. Hence the question, should bilateral salpingectomy be offered to women of low risk for ovarian cancer instead of tubal ligation?

Risk reduction for ovarian cancer

Tubal ligation is the commonest form of permanent contraception worldwide with high efficacy and low complication rates. In addition, data from large cohort studies also show that tubal ligation is associated with a decrease in the risk of ovarian cancer by about 25 per cent.[7,8] Interestingly, hysterectomy performed in isolation (in other words, without bilateral salpingo-oophorectomy or bilateral salpingectomy) also decreases the risk of ovarian cancer, by about 20 per cent.[7] The decreased incidence of ovarian cancer associated with both tubal ligation and hysterectomy is more pronounced for non-serous tumours, especially the endometrioid and clear cell sub-types, than for HGSC.[8] It has been postulated that the inverse effect on non-serous tumours by tubal ligation and hysterectomy may be via a common mechanism; for example, prevention of retrograde menstruation or reduction of ovarian function owing to compromised blood supply.[7]

Recent population-based studies from Sweden and Denmark have confirmed the inverse effect of tubal ligation and hysterectomy on the risk of epithelial ovarian cancer and also showed, for the first time, that salpingectomy decreases the risk of epithelial ovarian cancer in the general population. Bilateral salpingectomy decreased the risk of ovarian cancer by 35–42 per cent, whereas the effect of tubal ligation was more modest (a 13–28 per cent reduction).[9,10] Furthermore, a Markov Monte Carlo simulation study predicted that salpingectomy would decrease the risk of ovarian cancer by 38 per cent and 29 per cent when compared to hysterectomy and tubal ligation, respectively.[11] These data showing superior reduction in ovarian cancer associated with salpingectomy would appear to support the theory that HGSC arises from STIC lesions in the fimbria, with tubal ligation and hysterectomy having a lesser effects on this aetiology. Indeed, salpingectomy may also be expected to decrease the risk of endometrioid and clear cell ovarian carcinomas, similar to tubal ligation and hysterectomy.[7]

Advantages and disadvantages

Advantages

As discussed above, salpingectomy appears to be associated with a reduced risk of ovarian cancer for both high-risk and low-risk populations. This effect is significantly greater than that achieved with tubal ligation.

Compared to tubal ligation, salpingectomy is associated with a lower incidence hydrosalpinx, and eliminates the need for re-operation for this indication (estimated to be about eight per cent up to 30 years post-hysterectomy).[12]

Compared to tubal ligation, salpingectomy has a lower failure rate and probability of subsequent ectopic pregnancy. Indeed, salpingectomy has the lowest rates of all sterilisation methods for contraception failure rate and ectopic pregnancy.[2]

Disadvantages

It is now well established that women at low-risk of ovarian cancer should generally retain their ovaries until at least the age of 65 years, in order to decrease mortality and morbidity related to coronary heart disease, osteoporosis-related fracture and cognitive dysfunction and dementia (see RANZCOG Statement C-Gyn 25: Managing the adnexae at the time of hysterectomy for benign gynaecological disease). Therefore, there is some concern that opportunistic salpingectomy may damage ovarian collateral circulation, resulting in premature ovarian failure. Several studies comparing laparoscopic hysterectomy to laparoscopic hysterectomy plus bilateral salpingectomy showed the addition of salpingectomy has no short-term effect (up to three months) on ovarian function and reserve as determined by anti-Mullerian hormone, follicle-stimulating hormone and oestrodiol levels, antral follicle count, mean ovarian diameter and peak systolic velocity.[13,14] Although longer term follow up is necessary, these early data suggest that bilateral salpingectomy has no adverse effect on ovarian function. Furthermore, it could be postulated that early ovarian failure related to salpingectomy would only result from inadvertent damage to the ovarian circulation owing to poor surgical technique.[2]

Most gynaecologists are able to perform bilateral salpingectomy at caesarean section and at laparoscopy, although the procedure is more complex than for tubal ligation. The addition of salpingectomy at laparoscopic hysterectomy does not appear to significantly affect operative time, post-operative stay, time to return to normal activity or post-operative haemoglobin.[14] There are, however, no prospective study data available comparing the perioperative complications associated with bilateral salpingectomy and tubal ligation. Given the data from studies comparing hysterectomy to hysterectomy plus salpingectomy, it is unlikely that there would be a significant difference in complication rates between salpingectomy and tubal ligation performed at caesarean section. At laparoscopy, however, there is at least one point of difference between the techniques as performed at open surgery. In particular, laparoscopic tubal ligation is usually performed through two port sites (one at the umbilicus for the laparoscope and another suprapubically for the clip applicator). Laparoscopic salpingectomy, on the other hand, would generally require the addition of at least one additional lateral port (to allow for a grasper and a laparoscopic energy source) and perhaps a surgical assistant (depending on the surgeon's level of skill). Prospective comparative studies of laparoscopic tubal ligation and

salpingectomy perioperative outcomes (operating time, postoperative pain, time to discharge, complications and so forth) are necessary to delineate risk-benefit profiles for these procedures.

Compared to tubal ligation, salpingectomy eliminates the chance of future tubal re-anastomosis and necessitates *in vitro* fertilisation if there is a change of mind regarding future childbearing.

What should I do?

The choice between salpingectomy and tubal ligation is not clear, as evidenced by recent professional body statements. For example, the Working Group Gynecological Oncology (AGO, Germany) states: 'there is insufficient evidence to currently recommend opportunistic salpingectomy at all hysterectomies and other gynaecological procedures'.[15] The American Congress of Obstetricians and Gynecologists acknowledges the likely benefit of salpingectomy on reducing the incidence of ovarian cancer, but notes: 'the approach to hysterectomy or sterilization should not be influenced by the theoretical benefit of salpingectomy; that is, for example, a total laparoscopic hysterectomy should not be performed instead of a vaginal hysterectomy for the sole purpose of performing concomitant salpingectomy'.[16] The Society of Gynecologic Oncology (USA) concluded that important ovarian cancer prevention strategies may include tubal ligation as well as opportunistic salpingectomy after childbearing is complete at the time of elective pelvic surgeries; for example, at the time of hysterectomy or as an alternative to tubal ligation.[17] RANZCOG recommends: 'consideration should be given to performing bilateral salpingectomy instead of tubal occlusive procedures for female sterilisation' (see RANZCOG Statement C-Gyn 22: Female Sterilisation by Filshie Clip Tubal Occlusion).

It is quite likely that bilateral salpingectomy, instead of tubal ligation, will be found to be in the best interests of the patient. For now, given the uncertainty about the risk-benefit profile of salpingectomy over tubal clips for permanent sterilisation, the choice should be made on a case-by-case basis. Most importantly, the patient should be included in the decision-making process.

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Journal Club

Had time to read the latest journals? Catch up on some recent O and G research by reading these mini-reviews by Dr Brett Daniels.

HRT and cognition

One of the desired benefits of postmenopausal hormone replacement therapy (HRT) is that of improved cognitive function. Like many aspects of HRT research, results have been mixed. The authors of this study describe a 'critical window' hypothesis in which previous studies suggest HRT given to recently menopausal women improves cognitive function, while HRT commenced after 65 years of age has an adverse effect on cognitive function. The Kronos Early Estrogen Prevention Study–Cognitive and Affective Study (KEEPS-Cog), an ancillary study of the Kronos Early Estrogen Prevention Study (KEEPS), is a randomised trial designed to investigate the cognitive and mood effects of up to four years of HRT in recently post-menopausal women. Over 700 women were randomly allocated to receive oral congugated equine oestrogens (CEE), transdermal estradiol or placebo for up to four years. Women were assessed on both mood and cognitive measures both at the beginning and end of the study.

The results of this randomised study did not show an improvement in cognitive function in women receiving HRT in the early menopause, compared to placebo. For mood outcomes, administration of low-dose oral CEE for up to four years was associated with statistically significant improvements in symptoms of anxiety and depression, mood symptoms commonly seen in recently postmenopausal women. Administration of transdermal estradiol did not benefit mood. Women considering HRT for menopausal symptoms may find the results of this study useful when comparing the risks and benefits in their particular case.

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Medical treatment of ectopic pregnancy

Ectopic pregnancy complicates one to two per cent of pregnancies. It is a potentially severe complication of early pregnancy and can lead to tubal rupture, haemorrhage and death if untreated. Fortunately, in well-resourced medical settings, ectopic pregnancy is often diagnosed early, owing to improvements in ultrasound and biochemical testing. Once diagnosed, treatment of ectopic pregnancy may be expectant, medical or surgical, with the choice of modality depending on clinical situation, local protocols and patient and clinician preference.

Methotrexate, which inhibits the metabolism of folic acid, is the most commonly used drug for the medical treatment of ectopic pregnancy. Methotrexate may be given in multiple and single-dose protocols but is not invariably successful, with 10–25 per cent of women receiving methotrexate for the treatment of ectopic pregnancy eventually requiring surgical treatment. A recent paper by Capmas and Fernandez reviews the current evidence of using a combination of gefitinib and methotrexate to treat ectopic pregnancy, with the aim of improving the effectiveness of the treatment.[1] Gefitinib is an epidermal growth factor receptor (EGFR) inhibitor that is used in the treatment of non-small cell lung cancer and in breast cancer. It can be taken orally, and placental tissues have been found to have the highest expression of EGFR of human non-malignant tissues, making it well suited to the treatment of ectopic pregnancy.

In one small study, 12 women received both a single dose of methotrexate and gefitinib over a one week treatment protocol. Ten out of 12 women's (83 per cent) ectopic pregnancies resolved with the combination of methotrexate and gefitinib and one out of ten needed a rescue methotrexate injection.[2] Compared to historical control patients treated with methotrexate alone, the median time to recovery was 11 days shorter in the combination treatment. A second study reported a case series of eight non-tubal ectopic pregnancies (five interstitial, three in caesarean scar) with all cases resolving without the need for surgery.[3] The authors of the review article conclude that, while more study is needed, there may be place in the future for the addition to gefitinib to methotrexate in the treatment of ectopic pregnancy.

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3 Horne AW, Skubisz MM, Tong S, Duncan WC, Neil P, Wallace EM, et al. Combination gefitinib and methotrexate treatment for non-tubal ectopic pregnancies: a case series. *Hum Reprod*. 2014;29(7): 1375-1379.

Reversal of hysteroscopic sterilisation

Selective serotonin reuptake inhibitors (SSRIs) are common anti-depressant medications used by many women in pregnancy. These two studies continue the examination of the evidence of a link between SSRI use in pregnancy and congenital abnormalities. Reefhuis et al report US data on 17 000 pregnancies with birth defects and 9000 pregnancies without birth defects, examining the effect of exposure to citalopram, escitalopram, fluoxetine, paroxetine or sertraline in the month before pregnancy or in the first trimester. High odds ratios excluding zero were observed for five birth defects with paroxetine (anencephaly 3.2, 95 per cent CI 1.6 to 6.2; atrial septal defects 1.8, 1.1 to 3.0; right ventricular outflow tract obstruction defects 2.4, 1.4 to 3.9; gastroschisis 2.5, 1.2 to 4.8; and omphalocele 3.5, 1.3 to 8.0) and for two defects with fluoxetine (right ventricular outflow tract obstruction defects 2.0, 1.4 to 3.1 and craniosynostosis 1.9, 1.1 to 3.0).[1] Wemakor et al report European data on over 40 000 pregnancies with infants with congenital abnormalities. SSRI exposure in first trimester pregnancy was associated with congenital heart defects overall (OR adjusted for registry 1.41, 95 per cent CI 1.07–1.86, fluoxetine adjusted OR 1.43 95 per cent CI 0.85–2.40, paroxetine adjusted OR 1.53, 95 per cent CI 0.91–2.58) and with severe CHD (adjusted OR 1.56, 95 per cent CI 1.02–2.39), particularly Tetralogy of Fallot (adjusted OR 3.16, 95 per cent CI 1.52–6.58) and Ebstein's anomaly (adjusted OR 8.23, 95 per cent CI 2.92–23.16). Significant associations with SSRI exposure were also found for ano-rectal atresia/stenosis (adjusted OR 2.46, 95 per cent CI 1.06–5.68), gastroschisis (adjusted OR 2.42, 95 per cent CI 1.10–5.29), renal dysplasia (adjusted OR 3.01, 95 per cent CI 1.61–5.61) and clubfoot (adjusted OR 2.41, 95 per cent CI 1.59–3.65).[2]

Both these studies showed paroxetine and fluoxetine were associated with an increased risk of congenital heart defects, while gastroschisis was also increased with SSRI use in pregnancy in both studies. As always, the risk of untreated depression during pregnancy must be weighed for each woman before a decision is made regarding the continuation or cessation of SSRIs in pregnancy. Furthermore, as Wemakor et al state, the individual increased risk of congenital anomaly with SSRIs with these results is in the order of 0.5 per cent per pregnancy. These papers do, however, suggest an increased association with some defects with paroxetine and fluoxetine compared to other SSRIs.

1 Reefhuis J, Devine O, Friedman JM, et al. Specific SSRIs and birth defects: bayesian analysis to interpret new data in the context of previous reports. *BMJ.* 2015 Jul 8; 351:h3190. doi: 10.1136/bmj.h3190.

2 Wemakor A, Casson K, Garne E, et al. Selective serotonin reuptake inhibitor antidepressant use in first trimester pregnancy and risk of specific congenital anomalies: a European register-based study. *Eur J Epidemiol*, 2015, doi:10.1007/s10654-015-0065-y.

Letter to the editor

Aldo Vacca remembered

In the world of vacuum extraction, three names are pre-eminent: Malstrom, Bird and Vacca. I had the privilege of meeting and working with Dr Aldo Vacca in 1978, at St Mary's Hospital Portsmouth, England, and participated in his seminal trial comparing the ventouse to forceps.

His constant accompaniments were his Pentax camera and the little paper diamonds that designated the anterior and posterior fontanelles attached to the heads of babies born by ventouse extraction. As a result of Aldo's tutelage, I became a devotee of this method of delivery and successfully introduced it to my public hospital in Western Sydney, where it remains the mainstay of assisted delivery to this day.

Our close friendship continued following our return to Australia and for many years I looked forward to his annual trainee workshops at our hospital. Aldo's abiding passion was the safe and effective means of fetal delivery with minimal maternal trauma. To Aldo the message was of paramount importance and, to avoid any conflict of interest, he forsook any monetary recompense for the design of his Omni Cup, such were the ethics of the man.

I add my voice to the growing chorus of supporters asking the College to honour his contribution in a more substantial way as this 'prophet' has not been recognised sufficiently in his own land.

A/Prof Criton Kasby
MBBS(Hons), MRCOG, DDU
University of Western Sydney

Notice of Deceased Fellows

The College was saddened to learn of the death of the following Fellow and Honorary Fellow:

Dr Roderick Donald Macdonald, NSW, on 16 May 2015
Dr David Maxwell O'Neil, New Zealand, on 2 August 2015

Correction

The article 'Viral gastroenteritis and Hepatitis A in pregnancy' by Robson and Daveson (*O&G Magazine* Vol 17 No 2 Winter 2015) states the Hepatitis A vaccine contains a live attenuated virus, so should not be given in pregnancy. This is incorrect: Hepatitis A vaccine is a killed vaccine.

Partners in learning

Dr Alec Ekeroma
FRANZCOG
Former President
PSRH

Kathy Gapirongo
BMid
President
PSRH

The Pacific Society for Reproductive Health's 11th conference took investing in partnerships to improve outcomes in the Pacific as its theme.

Attendees and organisers of the 11th PSRH conference, held in Suva, Fiji.

More than 400 reproductive health workers from all over the Pacific Islands attended the 11th Pacific Society for Reproductive Health (PSRH) conference held in Suva, Fiji, 7–10 July 2015 – the biggest so far. There were so many highlights, its best to start at the beginning:

- All participants attended a memorable welcome by His Excellency the President of Fiji, Sir Ratu Epeli Nailatikau, a most charismatic and down-to-earth President, who represents the best of everything Fijian.
- A large number of volunteers and organisations, including RANZCOG, assisted the local organising committee. The Fiji National University's Masters in Obstetrics and Gynaecology students had a crash course in how to organise a large conference.
- There were nine pre-conference workshops, running from one to three days. PSRH has realised the importance and potential effectiveness of workshops in imparting knowledge and skills. Using the pre-conference time for hands-on training is seen as a cost-effective use of trainers' and participants' time.
- The launch of two major initiatives in the Pacific Emergency Maternal and Neonatal Training (PEMNeT) Manual and the *Pacific Journal of Reproductive Health* has signalled the increasing capacity of clinicians, the capability of the organisation and the generosity of a large number of funders, including the United Nations Population Fund, Fiji National University and the Send Hope and Not Flowers charity.
- The Scientific program devised by Profs Rajat Gyaneshwar, Caroline Homer and Peter Stone, had a good mixture of plenaries and concurrent sessions – the latter sessions were grouped by professional interest and discipline, which addressed the different learning needs of the large number of participants.
- A large increase in the number of Pacific presenters enabled the conference to offer an excellent platform for new clinical research by postgraduate students.
- The Practice Improvement Marketplace, which started at PSRH 2013, was a major hit with participants. It was a chance for midwives to showcase their home-grown projects and programs and share these with their peers from other islands in the region.
- The cultural night saw 15 countries vying for the Cultural Performance Award. The largest contingent of conference participants from outside Fiji, the Solomon Islands team, took the coveted Cultural Performance Award 2015.
- The election of the new Board was based on the constitutional changes approved at the previous Biennial General Meeting. A keen contest for the Presidency of the organisation was witnessed for the first time and a new President, midwife Kathy Gapirongo, was elected.

In a conference studded with highlights and memorable moments, the happy faces against the backdrop of colleagues learning and sharing shall stay in the memory forever. We are especially grateful for the unique supportive relationship shared between PSRH and RANZCOG. The commitment and foresight of the RANZCOG Board and Council in making and sustaining its long-term investment in PSRH has enabled it to grow and flourish. This special partnership truly embodies the conference theme. Thank you all.

Taking local lessons from global experts

With the RANZCOG Regional Committee Pacific obstetrics and gynaecology trainee scholarship program, the College was pleased to bring six early-career trainees and specialists to the RCOG World Congress 2015, a joint RCOG/RANZCOG Event held in Brisbane, 12–15 April 2015.

RANZCOG awarded scholarships to three obstetrics and gynaecology trainees from Papua New Guinea, two junior specialists from Fiji and the solo obstetrician gynaecologist from Kiribati, who is also the Head of obstetrics and gynaecology at Tungaru Central Hospital, Tarawa, Kiribati. As part of the RANZCOG Regional Committee Pacific Scholarship program, two of these scholarships were provided by the Queensland Regional Committee and one scholarship was provided by the New South Wales Regional Committee. Feedback from all the visitors about the experience of attending this major international educational event in obstetrics and gynaecology was overwhelmingly positive.

Dr Robert Jones, registrar at the University of Papua New Guinea School of Medical and Health Sciences, has chosen a career providing reproductive healthcare in a country where attitudes and actions to improve the status of women still have a long way to go. He shares his insights and perspective of the Congress sessions relating to global health.

Dr Robert Jones writes

I was thrilled to see Brisbane for the first time and overwhelmed by the enormity of the Congress program itself and the number of professionals who were attending. I felt somewhat out of place among many of those who are well-renowned experts in the field of obstetrics and gynaecology. People who I had only ever met through reading a sentinel or journal article that changed practice in obstetrics and gynaecology or who were experts in fields that seemed almost a million miles away from anything we would ever do in Papua New Guinea.

Of most value to me was the knowledge gleaned from the sessions grouped under global health, as I found this the most applicable to my setting and the most palatable, if gaps in knowledge could be likened to essential foods that I were somehow missing from my diet. The global health sessions looked at how we could improve maternal health in low-resource or resource-limited settings. In my daily work, I find myself dealing with a maternal mortality rate that does not seem to be improving and a government that seems oblivious to the need to increase funding for healthcare in the country. Family planning interventions and the training of doctors and midwives seemingly make only a very small ripple in the pool of preventable deaths and a rapidly growing population.

What I realised through the lectures is that empowerment of women is the single most important factor that needs to be improved for our country. I still live in a society where a woman refers to her husband as her master and not her partner or even her co-worker as the bible puts it, no matter how Christian my country may claim to be. Our female literacy rates are less than 50 per cent and are unlikely to improve drastically in the next ten years. Countries such as Sri Lanka that have limited resources and are not as well off as Papua New Guinea presented rates of supervised delivery and maternal mortality rates that I could hardly believe and I left the audience thinking the presenter was guilty of promoting his government propaganda. To my surprise, he was telling the truth and, as I found out, Sri Lanka had achieved these promising results by empowering women. The literacy rates in Sri Lanka are some of the highest in Asia.

Reflecting on Papua New Guinea, I feel we have a long way to go in understanding that the most cost-effective measures of reducing maternal mortality, such as family planning and supervised delivery, are ineffective without good roads; cheap transport; free, quality education for all; and a crucial change of attitude towards more love and respect for our women. I saw a woman recently who wanted a tubal ligation at the time of her forthcoming delivery as she was scared of the dysfunctional labours she had had in her previous pregnancies, but when she discussed the matter with her husband he accused her of using tubal ligation as a means to secretly commit adultery and not fall pregnant later on. She continues to face an uncertain future with the ever-present risk of dying from an unintended pregnancy. Her current pregnancy was unintended, but such pregnancies are usually accepted.

I am currently conducting a research project that explores how much the country would gain (in terms of demographics, health, economics and so forth) if it addressed the unmet family planning needs either quickly or slowly as opposed to no change at all in the unmet need for family planning. Dr Elisa Kennedy has conducted such a study for Vanuatu and the Solomon Islands and I am keen to do something similar for my country.

In summary, there was much that I took away from the conference, but I've focused here on my views on the global health sessions. I am sure I can confidently speak on behalf of my Pacific colleagues in saying we all truly appreciated the experience and were privileged to be a part of this unforgettable Congress.

Queen's Birthday Honours Awards

The College congratulates the following Fellows, Diplomates and Friends of the College Collection on their awards:

Member (MNZM) of the New Zealand Order of Merit

- Dr Norman Edgar Maclean of Invercargill, New Zealand (FRANZCOG). For services to obstetrics and gynaecology.

Member of the Order of Australia (AM)

- Dr Barry Eastwood Christophers, of Malvern East, Victoria (a Friend of the College Collection). For significant service to the Indigenous community through advocacy roles, and to medicine as a general practitioner.

Medal (OAM) in the General Division

- Dr Brian John Norcock, of Naracoorte, South Australia (DRANZCOG). For service to rural medicine, and to the community of Naracoorte.
- Dr David Howe, of Orange, NSW (DRANZCOG). For service to children's health, and to the community of Orange.

A gathering of Friends

Ros Winspear
College Archivist

On Thursday, 23 April, the Honorary Curator, Prof Caroline de Costa, hosted a Morning Tea for the Friends of the College Collection. The event was held at College House, Melbourne.

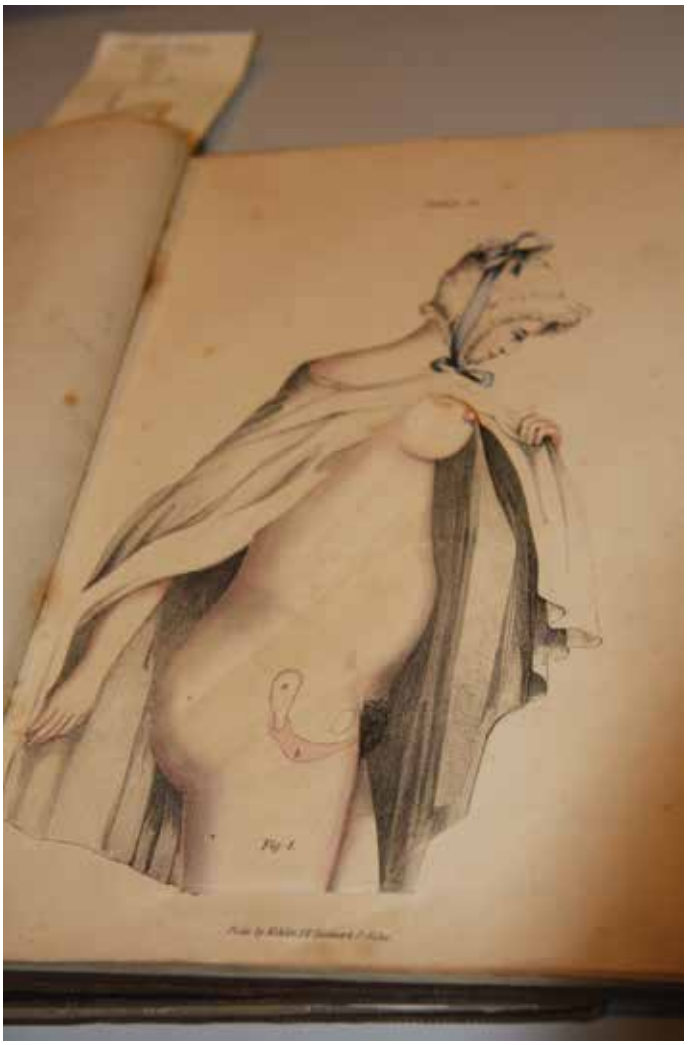
Prof Caroline de Costa with the print The Dawn of Abdominal Surgery by Cornwell.

Approximately 40 guests attended the function in the Frank Forster Library. The President, Professor Michael Permezel, was in attendance and welcomed the Friends to the College. He thanked them for their tremendous support over the years. Prof de Costa then gave a fascinating talk about one of the historic prints in the Collection and its significance in the history of medicine. The Dawn of Abdominal Surgery by Dean Cornwell depicts Dr Ephraim McDowell performing the first successful ovariotomy, in Danville, Kentucky in 1809. The patient, Jane Todd Crawford, lived on until the age of 73. The print is one of a series entitled Pioneers of American Medicine, and was the gift of Dr Frank Forster.

Later in the morning, guests were given short tours and had the opportunity to view some of the interesting items in the collection, including the rare books. The Friends and their guests viewed the displays while the historical staff explained some of the details. The staff were assisted by former Honorary Curator Dr Geoffrey Bishop, who demonstrated the use of one of the pairs of forceps on display in the special cases.

The secret instrument display provides a historical account of the story of the Chamberlen forceps that were hidden away in an attic for over 100 years until their discovery in 1813. The forerunner of modern obstetric forceps was devised by William Chamberlen and his sons in England in the 17th century.

The Chamberlen family were Huguenots who had fled to England to escape persecution. The forceps were kept secret for over



Top: Illustration from Obstetric Tables by George Spratt, 2nd ed. 1837. Bottom: Example of the flap technique used in Spratt's Obstetric Tables.

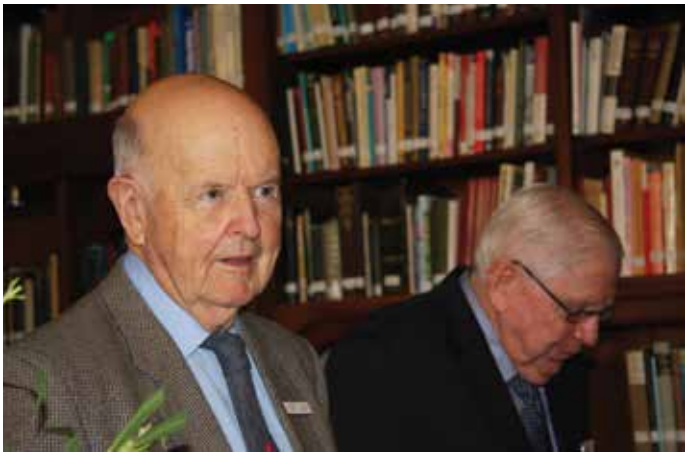
Top: Dr Sam Howes viewing The anatomy of the human gravid uterus, by William Hunter, 1774. Bottom: Detail of illustration from Hunter's Anatomy of the human gravid uterus.

a century and only used by members of the family. They later became known as 'The Secret Instrument'. William's sons, Peter the Elder and Peter the Younger, became members of the Barber Surgeons Company and were both court physicians at various times. Peter the Elder was imprisoned in 1612 for not attending compulsory lectures, but was released following intercession by his royal patron, Queen Anne, wife of James I. He then remained the court physician, attending Queen Henrietta, wife of Charles I.

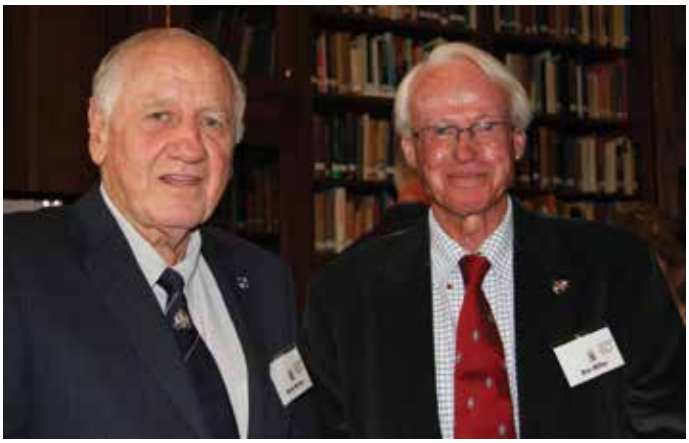
Dr Peter, son of Peter the Younger, was admitted to the College of Physicians and followed his father and uncle as court physician. He attempted to organise the midwives of London into a guild

Dr Geoffrey Bishop demonstrating the use of one of the obstetric forceps in the Museum.

Dr John Green with the photograph of his father Dr John Green taken by Dr Julian Smith, 1947.



Dr Gilbert Wallace and Dr Sam Howes in the Frank Forster Library.



Dr Barry Butler and Dr Eric Miller.

Dr Sam Howes and Prue Forster.

and was to be paid a fee for each delivery. Following complaints, he was dismissed by the College and retired to Woodham Mortimer Hall in Essex. It was there, in 1813, that the forceps were discovered after being hidden under floorboards in an attic for 150 years. The instruments were presented to Mr H H Carwardine, a friend of the discoverer, who passed them on to the Royal Society of Medicine and, ultimately, to the Royal College of Obstetricians and Gynaecologists (RCOG). The RCOG commissioned a limited number of facsimiles of the original forceps to be made, one of which is on display. The facsimile was given to the College Collection by Dr Lawrie Brunello, a former President of the College.

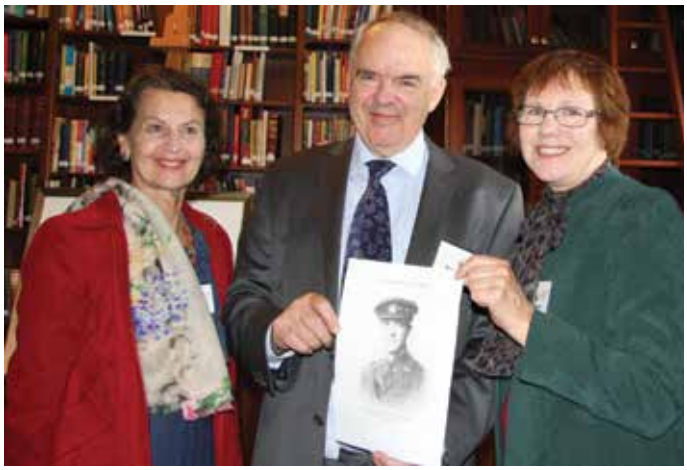
The contraception through the ages display was available to view. It provides a history of contraception from early times and includes examples of most contraceptives. The items were donated by Drs Frank Forster, Tom Roberts and others.

Friends and their guests were also able to see the Auzoux papier-mache models of a fetus. The models represent the development of a fetus over the nine months of pregnancy and were made by Dr Louis Auzoux (1797–1880), a French physician. As a medical student studying anatomy in the early 19th century, Auzoux found that the human cadavers he was dissecting deteriorated rapidly and wax models were not readily available. He developed a

Helen Coutts-Green, Dr John Green and A/Prof John Leeton.

Back: Michael Bishop and Eric Westrup. Front: Hon Rod Kemp, Dr John Green, Daniele Kemp and Mary Wilson.

Dr John Green, Dr Geoffrey Bishop and Dr Di Tibbits with painting The Midwife by Brian Dunlop.



Daniele Kemp, Hon Rod Kemp and Mary Wilson with photograph of Dr Arthur Wilson in WWI uniform.

special method of papier-mâché modelling and opened a factory in 1827 to manufacture human, veterinary and botanical models. The Auzoux models on view were a gift from Dr Nic Jools.

A Japanese general surgery kit in a timber box was on view for the event. It was originally used by a Japanese soldier in New Guinea during World War II. Dr Ted Spring, a GP obstetrician serving in New Guinea during the war, managed to rescue the kit and bring it back to Australia. It was given to the College Collection by his son, Dr Mark Spring.

The portable trichloroethylene anaesthesia apparatus, in a travel case, was used during homebirths in the 1940s. The case lid bears the manufacturer's stamp CIG [Comweld], a company that operated in Australia from 1935. It was used by Dr Ted Spring and donated by his son, Dr Mark Spring.

During the morning, some Friends arrived with gifts for the Collection and these were gratefully received by the Honorary Curator. The following items were donated:

- From Dr John Green, memorabilia and papers relating to his father the late Dr John Green.
- From Hon Rod Kemp, a photograph of his grandfather Dr Arthur Wilson in his World War I uniform.
- From Dr Di Tibbits, The Midwife, a watercolour by Brian Dunlop depicting a midwife in uniform of the late 19th century.

We thank the Friends for these especially valued additions to the College Collection.

The Friends of the College Collection

The Friends of the College Collection (FOCC) are dedicated to maintaining the history of the specialty and women's health. The Friends of the College Collection was established in 1989, by Dr Frank Forster, to raise funds to support the ongoing costs of developing, maintaining and conserving the Collection. Membership of the 'Friends' by donation is open to College members as well as those in the wider community with an interest in history of medicine, women's health or the specialty of obstetrics and gynaecology. We are grateful to the Friends for their generosity in continuing to support our Historical Collections.

Obituaries

Helen Anderson
(1952 – 2014)

Helen was born in Brisbane on 12 September 1952, but her family moved to Melbourne and she went to primary school in Camberwell followed by secondary schooling at Camberwell Girls Grammar School.

Her undergraduate education was at Melbourne University, where she was a vivacious and popular student and where she met her future husband, Steve McLaughlan. She graduated in 1976. She did her early years of work at the Austin Hospital and commenced her specialist training at the then Mercy Maternity Hospital in 1980. As was then the custom, she went to the UK and worked for several years as a registrar in Stoke on Trent. She received her FRACOG in 1989. In 1997, she became a Fellow of the Royal College of Obstetricians and Gynaecologists.

Helen was appointed as a consultant at the Mercy on 1989 and, at the same time, commenced private practice in East Melbourne. In her time at the Mercy, Helen had a number of roles including gynaecologist at the Austin Hospital, director of the menopause clinic and honorary senior lecturer in the University of Melbourne Department of Obstetrics and Gynaecology. Ultimately, Helen became Head of one of the units of obstetrics and gynaecology – initially the Andersen Unit and then renamed the Yarra Unit when the hospital relocated to Heidelberg.

Helen was a much-loved consultant at the Mercy, known for her cheerfulness, her positive outlook, her hard work, her friendliness and compassion as well as for her clinical skill. She was a mentor and role model for students and Trainees, particularly female Trainees, who could see that it was possible to have a busy and highly successful career and still have time for a family and a life away from work.

Helen had a very successful private practice and was much loved by her patients, many of whom were devastated at her sudden retirement.

Helen had many interests outside her professional life, including bridge, golf and gardening and loved to spend time at the beach at Anglesea or Noosa, cultivating a suntan.

Helen passed away on 8 December 2014. She was immensely proud of her three children – Will, Emma and Lucy. She is survived by her husband Steve and her children. She is greatly missed.

Bernadette White
FRANZCOG

Laurie Thomas Williams
(1946 – 2015)

Laurie Thomas Williams was born in Geelong, the son of a train driver. The family moved to Footscray where Laurie attended Tottenham Primary School and obtained a scholarship, gaining entry to Essendon Grammar School in year 7, which began a life-long association with the school. Laurie obtained his medical degree from Monash University in 1971 and subsequently undertook his training in obstetrics and gynaecology at the Royal Women's Hospital. In 1977 he obtained his MRCOG and was awarded the gold medal. Following this Laurie went overseas, as was the practice at the time, to obtain further training and worked at Heatherwood Hospital in Ascot before returning home and establishing a practice in the Western suburbs. He was elevated to Fellowship in 1989.

Laurie was always conscious of his humble beginnings and chose to work in the more disadvantaged areas of Melbourne. He was a consultant at Western General, Essendon and District Memorial and Sunshine Hospitals until late in his career. Despite his busy clinical commitment, he found time to be on the Board of Management of Penleigh and Essendon Grammar School and was the Chairman for 12 years; during this time he undertook new developments at the school and was instrumental in purchasing a large parcel of land that is now home to the sports pavilion.

Psoriatic arthritis that affected his hands forced him into retirement from clinical practice in 2003. His wealth of medical experience and his personable, softly spoken manner were, however, usefully employed in the area of hospital management, which he embraced after obtaining an MBA. He managed a day procedure centre, medical consulting rooms in Wyndham and was planning to establish a private hospital in the Western suburbs. His untimely death resulted from aortic stenosis complicated by pulmonary oedema.

Laurie was a valued colleague and friend to many of us and will be sorely missed. He is survived by his wife Denise, his four children and three stepchildren.

Graeme Dennerstein
FRANZCOG

Raphael Kuhn
FRANZCOG

Sam Sfameni
FRANZCOG

Michael Gronow
FRANZCOG
Vic