

# O&G

Magazine

Vol 12 No 1 Autumn 2010

**The general gynaecologist:  
an endangered species?**



ENDANGERED  
SPECIES  
NEXT 30 km





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# From the President



**Dr Ted Weaver**  
President

It seems odd sitting here in the Queensland summer heat and humidity, writing a column for the Autumn edition of *O&G Magazine*. Keats' 'season of mellow fruitfulness' seems a world away, yet Keats himself seems altogether more real, with the release of the movie 'Bright Star' about his short life and the difficulties he had in succeeding in his chosen career. Life often imitates art, never more so than in medicine, and the current issue of *O&G Magazine*, with its focus on the 'general' gynaecologist is timely, as a general specialist these days may find himself/herself struggling in defining

a practice role in times of increasing subspecialisation. The clear message from government is that Australia and New Zealand both need a predominantly general specialist workforce in obstetrics and gynaecology, underpinned by a well-trained subspecialty workforce, that is strategically placed to meet the workforce needs of two geographically diverse countries.

*'...it is reasonable to ask questions about how we can better utilise training time to better equip future Fellows for the scope of practice that they wish to do when they attain Fellowship, and also to ensure there are adequate numbers of generalist Fellows to meet the workforce needs of both countries.'*

One of the principal issues we have been grappling with at Council level at the College has been the training program we currently have for Trainees and the outcomes of that training. A number of problems have been identified in training, for example, with difficulties in ensuring Trainees achieve adequate numbers of different gynaecological surgical procedures, not all Trainees being exposed to all the subspecialties during their training, and Trainees abandoning practice quickly in one or other half of the specialty on attaining Fellowship. Thus, it is reasonable to ask questions about how we can better utilise training time to better equip future Fellows for the scope of practice that they wish to do when they attain Fellowship, and also to ensure there are adequate numbers of generalist Fellows to meet the workforce needs of both countries.

## **RANZCOG Training Program Working Party**

Because of the difficulties we are having in training all our Fellows across the breadth of our specialty, the Executive Committee of the College has convened a Training Program Working Party. This group has wide Terms of Reference. It will examine our current methods of assessing Trainees and will look critically at the training program, in particular the elective period in years 5 and 6. There have already been recent discussions about modular training in these years and it may be that this will provide part of the solution in delivering new graduates with different scopes of practice, on attaining Fellowship.

The results of the RANZCOG Workforce Surveys and Practice Profile data, obtained from Fellows through an online questionnaire last

year, will prove valuable in estimating our future workforce needs. It will also help in defining the different scopes of practice undertaken by Fellows at different stages of their careers, once completed training, although it is increasingly obvious that Fellows choose a scope of practice to suit their interests and training virtually as soon as they have obtained Fellowship.

Clearly, this is core business for the College and the results of the deliberations of this Committee, which will probably take approximately a year to finalise, will no doubt be debated and refined by the next RANZCOG Council and by the Fellowship at large. It is important that we maximise training opportunities and try to ensure that new Fellows are as well-equipped as they can be for the scope of practice they undertake on successful completion of the College's training program.

## **Maternity Reforms**

The Maternity Reform agenda put in place by the Australian Federal Health Minister, the Hon Nicola Roxon MP, is continuing. To guide the process, the National Health and Medical Research Council (NHMRC) have convened a guidance group of 'key stakeholders' in maternity care to develop an overarching guidance document for the use of practitioners engaging in collaborative models of maternity care. The group has developed a document, which is to be considered by the NHMRC Board in March 2010 and will then be put out for consultation. It is my intention to circulate the document to the Fellowship and would appreciate any considered feedback.

The Maternity Services Action Group (MSAG), which is a multidisciplinary group involving all the major participants in maternity care and which is advising the Government, is due to meet again on 18 March 2010, to further refine the proposed reforms.

In December 2009, I appeared before the Senate, who were enquiring into the Maternity Reform Bills that were currently before it. A number of groups, including the Australian College of Midwives, the Maternity Coalition, Home Birth Australia, the Australian Private Midwives Association and the Australian Nursing and Midwifery Council, spoke before the Senate prior to RANZCOG's appearance. It was interesting that RANZCOG was granted an appearance with the Australian Medical Association (AMA) and it was thus a joint sitting before the Senate with the AMA President, Dr Andrew Pesce, and AMA representative, Mr Francis Sullivan, and myself. The link to the Hansard of that day follows: [www.aph.gov.au/Senate/committee/clac\\_ctte/health\\_leg\\_midwives\\_nurse\\_practitioners\\_09\\_nov09/report/index.htm](http://www.aph.gov.au/Senate/committee/clac_ctte/health_leg_midwives_nurse_practitioners_09_nov09/report/index.htm).

Also in December 2009, NHMRC convened a multidisciplinary group meeting of all maternity stakeholders which was part of the consultative development of its guidance document. I have circulated this document to all RANZCOG Fellows for feedback. This meeting really did not resolve anything, but one of the outcomes was that I gave an undertaking to develop, with the Australian College of Midwives, agreed referral guidelines for collaborative maternity care. The College, in late 2008, developed, and subsequently endorsed, referral guidelines at Council, and RANZCOG has been particularly concerned that the Australian College of Midwives guidelines, and not our referral guidelines, seem to have become a de facto standard around Australia. If collaborative models of care are to be successful, they have to be underpinned by previously agreed referral guidelines, and the



Government is considering funding the process to merge the two guidelines. Once completed, the guidelines should also apply to the New Zealand maternity system.

Throughout all the maternity meetings, it has been a theme and complaint by some midwifery and consumer groups that RANZCOG Fellows will not engage in collaborative models of care, as they are not obligated to do so, under the proposed Roxon reforms. The whole thrust of RANZCOG's position throughout the maternity reform agenda has been that team-based maternity care, with different health professionals involved, brings about the best outcomes for pregnancy.

I think if RANZCOG Fellows fail to provide collaborative maternity care with known midwives, we will incur the ire of Government and may then have to put up with an imposed solution. I would thus implore Fellows of the College to try to work collaboratively with midwifery colleagues, to try to ensure that collaborative maternity care is a success and does in fact lead to better maternity outcomes.

In New Zealand, the Health Minister, the Hon Tony Ryall, has flagged a review of the New Zealand maternity system. He has identified four areas of review, which are detailed below:

1. Developing national quality and safety standards, including maternity service standards, clinical indicators and key performance indicators.
2. Revising referral guidelines to include protocols for transfers of care and emergency transfers.
3. Improving maternity information systems and analysis, as recommended by the Perinatal and Maternal Mortality Review Committee.
4. Developing standardised, electronically transferable maternity notes, to improve communication in transfers to other professionals.

With anecdotal reports abounding about the New Zealand maternity system, these proposed measures seem timely and should allow adequate data collection and analysis to highlight strengths or weaknesses within the system.

### Meeting with Medical Benefits Task Review Group

The Department of Health and Ageing (DoHA) has requested that medical colleges participate in consultations regarding the Medicare Benefits Schedule (MBS) Quality Framework and new listing process for item numbers in the MBS announced in the 2009-10 Budget. In the 2009-10 Budget, the Australian Government announced that it would provide \$9.3 million over two years to develop and implement a new evidence-based framework for managing the MBS into the future – the MBS Quality Framework. The Quality Framework will establish new listing, pricing and review mechanisms that ensure that prospective and already listed items are effective and safe, likely to lead to improved health outcomes for patients and represent value for money. The Australian Government will consider the future of the program in the 2011-12 Budget.

The MBS Quality Framework involves four key elements:

1. Introducing a time-limited listing for new MBS items that do not undergo an assessment through the Medical Services Advisory Committee (MSAC).
2. Requiring an evaluation process for all time-limited items at the end of the time-limited period and before items can be approved for long-term MBS listing.
3. Strengthening arrangements for appropriately pricing and listing new MBS services.
4. Establishing systematic MBS monitoring and review processes to inform appropriate amendment or removal of existing MBS items.

This promises to be an important area of College activity in the next 12 months.

### AusAID Meeting

In December 2009, Senior College representatives and members of the RANZCOG's Asia Pacific Committee met with AusAID in Canberra to discuss RANZCOG's program in the Asia Pacific region. This was a follow-up discussion to the meeting that we had with Mr Bob McMullan, Parliamentary Secretary for International Development Assistance, on 24 July 2009. Earlier in 2009, the Asia Pacific Committee developed a series of issues they wanted to discuss with AusAID, which included matters such as support for both the University of Papua New Guinea and Fiji School of Medicine, broadband support in Papua New Guinea, and the development of other educational programs within the Pacific region.

The meeting was chaired by Dr Jane Lake, Assistant Director General and Senior Advisor within the Pacific branch of AusAID. Dr Lake outlined the AusAID Program in the Pacific and how aid packages were being delivered. She pointed out that AusAID was most interested in forming partnerships with people and institutions within the regions, and that merely giving aid dollars was a thing of the past. AusAID was very eager to see sustained progress through multi-year partnership frameworks that they were developing with other agencies such as the United Nations Population Fund (UNFPA) and the United Nations Children's Fund (UNICEF). AusAID acknowledged that they would still need to provide financial support to both the University of Papua New Guinea and the Fiji School of Medicine, but were interested to see that those agencies had a business plan for the requirements they would need in the future.

The main outcome of the meeting was that the next meeting of the Asia Pacific Committee at the College in March 2010 would include representatives of AusAID; other agencies active in the Pacific region, for example, UNFPA; representatives of both the Fiji School of Medicine and University of Papua New Guinea Medical School; and the College, to jointly work out how the College, as a standards, educational and training body, can best deploy its limited resources in helping the poorer countries in our region. To finally develop a coherent long-term strategy should provide long-lasting regional benefits.

As our workforce ages and baby boomers move into retirement, we will have a large cohort of retired Fellows. The Executive Committee and Council have had some discussion about the potential benefits of a retired Fellows group being formed within the College. A meeting was held at College House in February 2010, with retired Fellow representatives from each State and from New Zealand, to canvass this issue. There are many ways such an organisation could benefit the College. Retired Fellows and I hope the initiative succeeds and turns into a vibrant 'grey power' arm of the College.

Fellows of the College have been sent a ballot paper, to vote on the Governance overhaul of the College that we have been undertaking through the lifespan of this Council. The results of the plebiscite will be declared at the March Council Meeting. If successful, the College will be governed by an Executive Board, underpinned by a Council structure that is similar to the one that we have now, with the main change being that the Board only, and not all Councillors, will have directorial responsibility for the College.

I would like to thank the Governance Group for their efforts in arriving at this current position and hope the new governance model, if approved, leads to more secure, accountable governance for the College.

The 2010 RANZCOG ASM is to be held in Adelaide from the 21 to 24 March. The meeting's theme, *'It's not all black and white'*, has been chosen to illustrate that, although we live in an era of evidence-based medicine, there are many areas in our specialty where evidence does not, and may not, give us all the answers we need as we strive to provide high quality care. The meeting, under the able chairmanship of Dr Chris Hughes, has produced a superb scientific program and I hope many of you and your colleagues can attend. The recent arrival of two large black and white objects at Adelaide Zoo may trigger your further interest in attending!

I would like to thank Councillors and members of all College committees, as the College could not function without your efforts.



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## INVITATION TO COMMENT

### *draft National Guidance on Collaborative Maternity Care*

NHMRC invites comment from all interested stakeholders on the draft National Guidance on Collaborative Maternity Care under section 13 of the *NHMRC Act (1992)*.

Copies of the Guidance and information on how to make a submission will be available from mid March 2010 for one month and can be found at:

<http://www.nhmrc.gov.au/guidelines/consult/index.htm#1>

NHMRC staff is offering consultations with all RANZCOG Chapters. For any questions or queries regarding the Guidance or the consultation process and how to make a submission please contact:

**Gill Hall on (02) 6217 9156 or  
[gill.hall@nhmrc.gov.au](mailto:gill.hall@nhmrc.gov.au)**



# From the CEO



**Dr Peter White**  
Chief Executive Officer

This time last year, I wrote this column for the corresponding edition of *O&G Magazine* with the smell of smoke still almost detectable in the Melbourne air and the realisation forming for many families and individuals that their world had been irreversibly shaken, their frame of reference of what was possible forever shifted as a result of one catastrophic event. As with disasters and near misses in medicine, the inevitable inquiry has taken place with the benefit of hindsight and important lessons will hopefully be learned. Even with divergent views being evident in

relation to some matters, new standards, rules and protocols will be formulated and put in place in an effort to prevent, or at least minimise, the chances of a recurrence of a cascade of events that result in tragic outcomes that many of those affected never thought could happen.

For medical practitioners, it is most likely a straightforward task to comprehend the desire to assign cause and manage future risk. As human beings, there is an added dimension that the benefit of hindsight can sometimes never really fully accommodate. Much in literature and music has been written about change that comes over time and the healing and hope that new seasons can bring as the promise of fresh dawns is realised when opportunity is grasped.

Dr Weaver, in his 'From the President' column in this edition of *O&G Magazine*, outlines some of the key activities that are contributing to a potential change of seasons for the College and its members: reviews of maternity services on both sides of the Tasman; governance changes; and recognition of the ways in which the specialty is changing that is forcing a fresh look at the way that training is arranged, conducted and assessed, are all of major significance for RANZCOG.

Additionally, in Australia, the implementation of the National Registration and Accreditation Scheme (NRAS) gathers momentum, with a recent discussion paper from the Medical Board of Australia (MBA) providing more clarity in regard to the proposed arrangements for specialist recognition and registration under the scheme. Of particular note in this regard are the proposed registration standards for limited registration in respect of doctors occupying Area of Need positions and those undertaking postgraduate training or supervised practice, following assessment as an overseas trained specialist by the College through the process coordinated by the Australian Medical Council (AMC). It is hoped that the arrangements relating to indemnity for the College, as a body conducting assessments as part of this process under NRAS, will be clarified with the relevant stakeholders (MBA, AMC) in the lead-up to the commencement of the scheme. This activity has long been recognised as one of potential risk for the specialist colleges and the mechanism exists to dramatically reduce this risk under the new scheme. Councillors will have the opportunity to become further informed in relation to the structure, policy and operation of NRAS through a presentation at the March Council Forum by Mr Michael Gorton AM, in his capacity as a member of the Agency Management Committee, which governs the Australian Health Practitioner Regulation Agency (AHPRA), the body responsible for

implementing the scheme. Information relating to NRAS may be found on the AHPRA website: [www.ahpra.gov.au](http://www.ahpra.gov.au). A link to the website of the MBA ([www.medicalboard.gov.au](http://www.medicalboard.gov.au)) may also be found on the AHPRA website.

The March Council Forum will also feature a presentation by the Chair of the College Appeals Committee, Ms Elizabeth Kennedy. The appeals process plays a significant role for organisations such as the specialist medical colleges, acting both as an independent mechanism for informal and formal review for those aggrieved by College decisions, as well as, concurrently, a source of information that enables reflection and improvement on organisational policies and procedures. The College appeals process allows for both informal review of College decisions, as well as formal hearing through the College Appeals Committee and allows for grounds drawn from the 2003 authorisation decision of the Royal Australasian College of Surgeons (RACS) by the Australian Competition and Consumer Commission (ACCC). These grounds are now generally accepted across the sector and referenced in the AMC's accreditation standards for specialist colleges. The importance of a robust appeals process for an organisation such as RANZCOG cannot be underestimated. The corollary to this is the importance of ensuring good process that is able to be effectively disseminated, understood and consistently applied by all involved in College activities.

*'... there is little doubt of the need for the specialist colleges, individually and collectively, to engage with State jurisdictions in relation to workforce and training matters, the two, of course, being inextricably linked.'*

I wrote in my previous column of the activity in Australia associated with health workforce planning and encouraged members wishing to gain an overview of such activity to access the website of the National Health Workforce Taskforce at: [www.nhwt.gov.au/](http://www.nhwt.gov.au/). Of particular note is the establishment of Health Workforce Australia (HWA), a body whose website describes it as:

*'...an initiative of the Council of Australian Governments, ... [that] ...has been established to meet the future challenges of providing a health workforce that meets the needs of the Australian community. Its initial roles will be to oversee the provision of financial support for pre-professional clinical training, facilitate locally based mechanisms for the placement of students into suitable training places, establish a health workforce statistical register to assist with longer term planning initiatives and to provide advice regarding workforce directions.'*

The first Chief Executive Officer of HWA, Mr Mark Cormack, has recently been appointed and a recent Communique from the Australian Health Ministers' Conference indicates that the composition of the Board of 13 members has been decided, with the Hon Jim McGinty being appointed as Chair of that Board. Whilst the initial focus of HWA will clearly be at undergraduate/ intern level, there appears little doubt that HWA will, over time, also delve into the postgraduate vocational training phase of medical education (and workforce) and its work will be of increasing interest to those involved in all stages of the continuum of medical education and healthcare delivery.

*Continued on page 10.*

At a jurisdictional level, there is also little doubt of the need for the specialist colleges, individually and collectively, to engage with State jurisdictions in relation to workforce and training matters, the two, of course, being inextricably linked. Of note is the activity being undertaken in a number of jurisdictions (for example, New South Wales and Queensland) in relation to the DRANZCOG and associated qualifications. It is important for the College to be actively involved at early stages of such activity, to ensure the most efficient and effective outcomes for all stakeholders.

The future of the Australian Government program known as the Support Scheme for Rural Specialists (SSRS), following the consolidation of a number of government programs in relation to specialist training as a result of the 2009 Federal Budget, appears to have been resolved, with the establishment of a program for medical specialists under the newly developed Rural Health Continuing Education program (RHCE). RANZCOG stakeholders will be appraised of details relating to the program as they become available. As with the previous SSRS arrangements, the program will continue to be coordinated through the Committee of Presidents of Medical Colleges (CPMC).

The draft recommendations from the MedEd09 Conference held in October 2009 have been circulated to stakeholder organisations for consideration. The conference, whose theme was 'Investing in Our Medical Workforce', involved significant input from representatives of a range of stakeholder bodies, including the CPMC, and the recommendations have been considered at a recent meeting of that forum. The recommendations are wide-ranging and both myself and Professor Kevin Forsyth, the Dean of Education of the Royal Australasian College of Physicians (RACP), have been nominated by the CPMC to continue our involvement with the conference from a CPMC perspective, by being the nominated CPMC representatives on the cross-stakeholder group formed to progress implementation of the recommendations from the conference.

For a lot of organisations, and RANZCOG is no exception, this part of the year sees the framing of the budget for the upcoming financial year, including the setting of subscriptions and College fees. As always, this part of College activity is taken extremely seriously, with much time being spent to ensure that the budget which is presented ultimately to Council is both prudent and realistic in its ability to be achieved. This year, during the budget preparation phase, there is an increased focus on the achievement of a balanced operating budget, net of any income from investment activity, as well as fee charges that are felt to be realistic in terms of enabling the College to conduct its business responsibly, while also representing, as far as is practical, the true cost of offering different aspects of College services and functions. The process of ensuring prudent financial operation of the College is an ongoing activity and members can be assured, by the multiple levels of oversight at Council and management level, of the desire to ensure the College delivers the best possible value for members within a dynamic operating environment. The range of activity now undertaken by the specialist colleges is diverse and the need to responsibly spread the cost of delivering this activity is increasingly understood by all.

All involved with College affairs are very aware of the impending election at the March meeting of Council for the next College President. A postal ballot is in progress at the time of writing this article, in regard to the governance arrangements of the organisation, and elections are to be held later in the year for positions on the Seventh RANZCOG Council, along with, possibly, the inaugural RANZCOG Board. As always, all members can be assured of the support of myself and the RANZCOG staff to any member who puts themselves forward for election, as the College continues to grow and mature. I look forward to another year of working with all RANZCOG members as we once again take on the task of stewarding RANZCOG for the future.



# Is the general gynaecologist an endangered species?



**Dr Brett Daniels**  
RANZCOG Trainee

The natural history of a medical specialty can take many different paths. Technological advances can create a specialty with no equivalent in the past or, through sweeping cure, make a task redundant overnight. There were no radiologists before x-rays and no longer are doctors required to treat smallpox. More commonly, a specialty emerges as knowledge and techniques become beyond the scope of the generalist. Especially in large centres, the generalist relinquishes more and more of their practice as their more specialised colleagues take the lion's share of the patient pool. If there is a

procedural skill defining the specialty, then the process accelerates with the 'generalist' seemingly defined by default as one who has not 'specialised'.

Within gynaecology there is still a strong representation of gynaecologists with a wide breadth of practice, but one only has to look at the physicians for one possible view of the future. In my own State, there are cardiologists and gastroenterologists, but general physicians are much thinner on the ground. Should the medical profession and the patients we serve be throwing bouquets or brickbats for these changes? A subspecialist, or a general O and G specialist with an interest in a subspecialty area, may ask if we wouldn't prefer our pelvic floor surgery be done by someone doing 150 a year rather than 20, while a general O and G specialist might ask if it is necessary for us to visit a subspecialist for surgery that they may have performed many times in their own career? While both are reasonable sentiments, a cynic might also ask if the subspecialist is not partially motivated by prestige and the general O and G specialist by the loss of the satisfaction they gained from treating their patients across the spectrum of their health. A trainee like myself may lament the loss of exposure to the breadth of our specialty, as more surgery becomes the province of subspecialty fellows rather than the general O and G trainee. A rural specialist may find the argument academic, with access to subspecialists being practically difficult in many regional and rural centres.

This issue of *O&G Magazine* asks the question: 'Is the general gynaecologist an endangered species?' If indeed we are endangered, we will not become extinct by the surgeons taking the care of women from us. Rather, it will be the division of gynaecology into ever more subspecialties and the reservation of techniques and operations by each of them. Colposcopy, mesh implants for prolapse and laparoscopic surgery all have subspecialties and societies lobbying for increased credentialing and training in their use. One can't deny that subspecialties provide highly-skilled practitioners and that complex problems are best managed by those of us with the finest training and experience.

Unfortunately, neither Australia nor New Zealand has a perfect health system and there is not a gynaecological oncologist or a urogynaecologist on every corner, or even in every city. Many

women, by necessity or choice, are treated primarily by a general specialist gynaecologist. It is these women and the doctors who care for them who will be most disadvantaged if non-subspecialist gynaecology practice becomes extinct.

As a nascent general O and G specialist, I would be disappointed if my care of women was restricted beyond the limits already imposed by our ethical and professional responsibility to practise within our training and expertise. There is no right answer to this question, but there is no question that gynaecology will decline as a specialty if we let it. We must be careful that the desire to increase our professionalism and expertise in ever more specific areas of practice, does not have the unintended result of limiting the ability of gynaecologists to continue to provide a comprehensive range of care to the women they serve.

## Gynaecology Practice Opportunity Sunbury Victoria

**Due to the forthcoming retirement of the incumbent in June 2010**, the opportunity exists to take over and expand an established gynaecological practice, with minimal opposition, based in Sunbury and Kyneton, Victoria.

Spacious rooms are available in a Consulting Suite in Sunbury, where a new Day Surgery facility is being built.

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**Please call Dr David Laurie on  
03 9218 5277 or 0407 333 040**

# Blast from the past

## *What did gynaecologists do in the 1980s?*

**Dr Bryan Cutter**  
FRANZCOG

**Ah, the 80s...Bob Hawke was living in The Lodge (which was just down the street from me). Shrimps were sizzling on our barbecues. Another drought was scaring the land. Across the country, gynaecologists were fighting off fatigue to face another day at the office. The more things change, the more they seem to stay the same.**

Twenty-five years on, it is fascinating to look back on that distant era when most Fellows of the College were both obstetricians and gynaecologists, and subspecialisation was in its infancy. The established subspecialists were gynaecological oncologists, although reproductive medicine was gaining enthusiasm amongst a band of enthusiasts.

As well as tending a large obstetric practice (that most personally disruptive but joyous of occupations), I also kept a busy general gynaecological workload. My special interests were infertility and cervical pathology. The internet was not a glimmer in a geek's eye and *Index Medicus* was printed in a font that could only be read through an operating microscope, across 26 sprawling volumes. *PubMed* was, of course, a pet name for the university bar.

Keeping up with advances in the specialty involved actually reading the journals as they arrived, attending conferences and workshops, and visiting experts at work. For example, I was influenced by the great South African surgeon Joel Cohen and made a pilgrimage to the famed Mayo Clinic in the United States.

In that era, about half of my time was devoted to gynaecological cases. My public hospital list, four treasured hours a week, actually saw knife applied to skin at precisely eight o'clock in the morning. The working day, of course, always began much earlier with ward rounds at the public and private hospitals soon after the sun rose.

Operating lists bristled with major cases. A typical list might begin with an elective caesarean section, followed by an abdominal hysterectomy, then a vaginal hysterectomy, capped off with two or three 'minor' cases. In later years, it was impossible to achieve this as starting times drifted ever later and turnover delays between cases grew ever longer.

I ran five operating lists each month at the private hospital in town. This was a special joy. The anaesthetists were keenly devoted to throughput and the nursing staff were regulars and had high levels of enthusiasm and expertise. Those were the days where I barely had to speak. I simply held out an open palm and the correct instrument was placed firmly on it. Surgical teams were consistent and contented, skilled and sure. Assistants had a solid grasp of current affairs and salacious gossip was verboten. Well, almost verboten.

I have taken a mental glance back at the typical operating lists of the era. Regular open cases included myomectomy, hysterectomy, tubal reanastomosis with the operating microscope, salpingolysis, salpingostomy and salpingectomy. Also featuring were ovarian cystectomies – removing dermoid cysts, endometriomata and other simple cysts. Laparotomy was used for tubal ectopic pregnancy.

Perhaps two out of five hysterectomies were accomplished vaginally. Anterior and posterior vaginal repairs were obviously all native tissue (mesh was confined to my insect screens at home). Before the advent of urodynamic studies, all assessment of urinary incontinence was by history and examination, and a few very basic clinical tests. Stress incontinence was managed surgically through an open incision, typically a Marshall-Marchetti cystourethropey or a Burch procedure. Occasionally, I would perform a snug anterior colporrhaphy and Kelly suture.

Dilatation and curettage, excisions of vaginal cysts, cone biopsies and Shirodkar cerclages also littered the lists.

*'The long apprenticeship and training demands requirements for competent practice across the breadth of the specialty. The impact on the work-life balancing act are too great. It seems inevitable that there will be greater subspecialisation.'*

Operating with the laparoscope was considerably less sophisticated in the 1980s. Infertility and pelvic pain was investigated. Simple ovarian cysts were resected. Endometriosis was cauterised, simple adhesions divided and Filshie clips applied. Oocyte retrievals for IVF were performed laparoscopically.

Patients with obvious ovarian or cervical malignancy were referred to a dedicated gynaecological oncologist, but I would often assist and manage their postoperative care.

I was involved in establishing a private IVF clinic in the mid 1980s, something new and exciting that brought hope where none existed before. We performed laparoscopic oocyte retrievals then embryo transfers. The timing of these procedures was sometimes chaotic, with the cases being added to the end of other surgeons' lists. Fondly, I recall the tremendous sense of camaraderie and grace that marked the age. Colleagues were readily available and happy to help with a second opinion and assistance in a clinically difficult situation, day or night.

The downside of all of this was the effect of a busy mixed practice on my long-suffering family. It appeared and was probably true that my patients came first. Barely a night would go by without



one or several phone calls. It was a time before mobile telephones and even pagers were not in general use. If I wanted to go to a shopping centre, I would need to tell a family member (and the delivery suite staff!) to which shop I was going. The term 'work-life balance' didn't exist then, presumably because there was no balance at all – the pressure was entirely concentrated at the business end of the scale.

For what it is worth, I suspect that busy solo practitioners will be consigned to history over the next few years. The long apprenticeship and training demands requirements for competent practice across the breadth of the specialty. The impact on the work-life balancing act are too great. It seems inevitable that there will be greater subspecialisation. The skills required of a gynaecological surgeon seem to be incompatible with the different training required of the aspiring obstetrician.

Of course, the sprawling Australian landscape and distances will still demand the well-rounded obstetrician and gynaecologist for some time yet. My advice to those just starting out? Simple. Follow what I call the 'three As': Affability, Availability and Ability. Be nice to work with, be available for your colleagues and the family doctors who rely on your counsel, and be able. The pleasant and available doctor who has a reputation for doing good work will always be welcomed and busy.

Bryan Cutter was one of Australia's busiest obstetrician gynaecologists up until his retirement in the early 2000s. Since then, he has been very busy with volunteer work, travelling and tending his 'long-suffering' family.

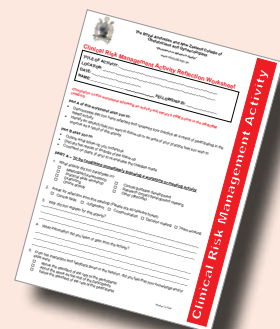
### **Clinical Risk Management Activity Reflection Worksheet**

**Have you attended a meeting or workshop that you wish to claim PR&CRM points for?**

If so this new worksheet is the one for you. It enables you to demonstrate that you have reflected on and reviewed in your practice as a result of attending a particular workshop or meeting. It also provides you with the opportunity to outline any follow-up work undertaken and to comment on plans to re-evaluate any changes made.

Download a form from the College website at:  
**[www.ranzcog.edu.au/fellows/prcrmactivitieshtml](http://www.ranzcog.edu.au/fellows/prcrmactivitieshtml)**  
**#RiskManagement**

For further information contact:  
**Jason Males**  
CPD & Curriculum Coordinator  
(t) +61 3 9412 2962  
(e) [jmales@ranzcog.edu.au](mailto:jmales@ranzcog.edu.au)



## Are you planning to survey members of RANZCOG?

**Did you know that your survey must be submitted to the RANZCOG CPD Committee for approval?**

This process was introduced in June 2000 to regulate the content and number of surveys being sent to the RANZCOG membership.

**Documentation required by RANZCOG:**

- RANZCOG criteria document detailing your survey
- Final survey
- Letter to be sent to participants with the survey
- Letter to CPD Chair from survey author detailing the purpose of the survey and identifying the class (eg Fellows/ Trainees/Diplomates) of College members that you wish to survey and the location (eg Australia, New Zealand or State).

RANZCOG requires that a disclaimer (as detailed in the approval letter) be appended to all approved surveys and that the applicant provide feedback of results and copies of any subsequent publications to the CPD Committee.

**For further information and the survey criteria document please contact:**

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(t) +61 3 9412 2921  
(f) +61 3 9419 7817  
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# General gynaecology – how trainees see their future in gynaecology?



**Dr Anneliese Perkins**  
RANZCOG Trainee

**When I was first approached to write an article discussing what plans my fellow trainees and I had for practising gynaecology once we finish training, many thoughts ran through my mind. The first response was: 'I don't like gynaecology, I don't want to do it at all!' Then I started to think. Is this statement really true for me anymore?**

Certainly, when I first started studying medicine I strongly believed I only wanted to do obstetrics. Obstetrics has always had the 'wow' factor for me. As a medical student, the things I remember most were the excitement and emotion accompanying the birth of a baby. At that time, gynaecology for

me was a long, drawn-out clinic dealing with complex problems I didn't understand. It wasn't until much more recently in my O and G training that I started to realise the possibilities that practice in gynaecology can present. In fact, if I am honest, there are areas of gynaecology which almost lured me away from my life-long dream of an obstetric practice and into subspecialty gynaecology. For now, I think I have settled on a happy medium of combined obstetrics and gynaecology for my future. But what do my fellow trainees think?

The question of what role gynaecology would play in the future for my fellow trainees appeared to be much simpler for them than it was for me. Overwhelmingly, the majority of trainees responded that they plan a combined practice of general obstetrics and general gynaecology. Most trainees questioned also planned to work within the public system.

What is it about general gynaecology that interests trainees? Certainly, diversity of practice is important. Every woman presents with a unique set of concerns and circumstances, making individualisation of her management options paramount. Gynaecology brings together both medical and surgical options unlike any other specialty. There is a mix of primary care and emergency medicine. Some would argue there is even a degree of psychiatry thrown in. We work with a wide range of people from many different backgrounds.

Throughout my training, I have been reminded many times that gynaecology offers more family-friendly work hours, through both flexibility and less work occurring after hours. There have been many suggestions that when I'm sick of being called in at all hours of the night to deliver a baby that just couldn't wait, a practice solely in gynaecology will start to become very appealing.

The main deterrent to working as a gynaecologist appears to be a perception that surgical experience is woefully inadequate for any trainee to feel confidence in their skills. An increase in medical

therapies, coupled with an increase in trainee numbers without a corresponding increase in available operating lists, has meant that trainees have to fight to get major cases. Major cases are so few and far between that each case seems as though it's the first one attempted and there is no opportunity to consolidate skills – everything that was learnt is lost by the time the next case comes around. I have been fortunate in the last 12 months to be employed in a centre where all gynaecology operating is shared over only four registrars, which has meant that I am starting to have regular exposure to major cases. Unfortunately, this was the first time in four years that I have done more than three or four hysterectomies a year. I only realised how little operating I was doing when I started discussing numbers with a trainee from New Zealand. Over four years, I had done a quarter of the number of hysterectomies that she had.

*'It is clear from a trainee perspective that the majority of trainees continue to desire a combined practice in obstetrics and gynaecology over a subspecialty career, yet feel the training does not currently fully equip them to achieve this.'*

Despite the lack of confidence, trainees feel, when they reach the end of the training program, this hasn't translated into a perception that it is necessary to branch into a subspecialty to become an adequate gynaecologist. To the contrary, there is overwhelming support for the ongoing role of a general gynaecologist. Certainly, subspecialist gynaecologists are necessary as leaders in the field – there are many things that will never be optimally managed by a generalist's broader but shallower skillset – but the role of a generalist is still crucial.

The importance of a general gynaecologist is perhaps most obvious in a rural setting. In Cairns, we have a catchment area for the whole of Cape York, islands of the Torres Strait and parts of Papua New Guinea. Our closest subspecialist is four hours away. Acutely, we need to have the skills to handle everything that comes in. Non-acutely, it is simply not financially or practically feasible to transfer every woman to the closest tertiary centre. Furthermore, caring for

many Indigenous women provides its own hurdles. Convincing women to travel to Cairns for care is challenging enough. Outreach visits to the communities have allowed for significant improvements in access to gynaecologists for many of these women. Many would (and do) choose no care over travelling six hours to see a colposcopist for an abnormal Pap smear.

One must not underestimate the emotional and physical toll on women travelling large distances to receive medical care. Often, they must travel alone leaving children at home for extended periods. They may require in-depth counselling by the subspecialist but face this without a support person. A simple 30-minute appointment can often take three days out of their lives and their work. Provision of general gynaecology closer to 'home' means the majority of women can access this care without the extended travel. Furthermore, when a more complex problem does require subspecialty care, often they are more accepting of the need for transfer to a tertiary centre when much of the initial investigation has occurred close to home.

Even within obstetrics, there is a need for general gynaecology skills. With increasing rates of caesarean sections come increasing rates of complications. Distorted anatomy, increases in unanticipated placenta accreta, even postpartum haemorrhage, warrant a knowledge of surgery beyond the caesarean. Peripartum hysterectomy can save lives, yet for many women, there will not be emergent access to a subspecialist to undertake this for her. There will always be an ongoing role for the general gynaecologist and training should focus on improving the skills of trainees to reflect this.

It is clear from a trainee perspective that the majority of trainees continue to desire a combined practice in obstetrics and gynaecology over a subspecialty career, yet feel the training does not currently fully equip them to achieve this. General gynaecology

remains not only crucial to the provision of healthcare for women, but also a desirable career, combining the benefits of many other specialities into one diverse, challenging and rewarding field.

I achieved a Bachelor of Medicine and a Bachelor of Surgery at the University of Adelaide. Since then, I have worked at Gold Coast Hospital, Mater Mothers' Hospital, Queen Elizabeth II Hospital, Logan Hospital and Cairns Base Hospital. I am currently a fifth year trainee at Cairns Base Hospital.

\* Dr Perkins interviewed a number of her fellow trainees in preparation for this article.

### Medical pamphlets

RANZCOG members who require medical pamphlets for patients can order them through:  
Mi-tec Medical Publishing  
PO Box 24  
Camberwell Vic 3124  
ph: +61 3 9888 6262  
fax: +61 3 9888 6465  
Or email your order to: [orders@mitec.com.au](mailto:orders@mitec.com.au)

You can also download the order form from the RANZCOG website: [www.ranzcog.edu.au](http://www.ranzcog.edu.au) .



# Life as a new O and G consultant in the 21st century

**Anonymous**  
FRANZCOG

**I was told by a wise professor that the first year of being a consultant would be the hardest year of my professional life. Surely not! Harder than finals? Harder than your first year as a house surgeon and those scary cardiac arrest calls?**

Harder than being the trainee representative and doing a master's degree at the same time? Well, I still have the rest of my career ahead of me, but I think he may have been giving me sage advice.

So what did the first year of being a consultant entail? First, you have to find a job – well, actually, first you have to decide what kind of job you want and where. There are so many options: fulltime or part-time, private, public or academic? So I chose them all.

Then you have to get the job, which requires things like your Fellowship, practising certificate and Medical Protection Society (MPS) membership, so in truth then, the first thing you have to do is fill in lots of forms and pay out lots of money. Not so hard I hear you say! Maybe not, but then you have to sign a contract, which requires reading lots of bits of paper and paying lots of money. Well, you pay the lawyer the money to do the reading for you. Or you could be like me and start work without one! Not to be advised.

*'My job changes on a day-to-day basis. I can be operating one day and designing a web-based survey the next.'*

So here comes the first day of work. 'Orientation' I hear you think. Well, that is unless you just have to start work! That's ok. It resembles things you remember from being a registrar and everyone expects you to ask questions. Sweet. Your first day achieved. So what is the next big hurdle. Your first day on-call perhaps? It sneaks up on you and suddenly you are filled with ridiculous questions. Do I wear my posh clothes so I look like a consultant and risk getting them dirty? They don't really go with my 'lucky' delivery suite shoes. Will I get home? Do I need to take clothes for tomorrow? Where should I sleep? Do I need to take the sleeping bag for the office? Where is my office? Suddenly it is upon you and you get through it and the only shock is still being there at 5pm the next day.

So you are surviving. You have found your office. All the paper work is signed. You have mastered the computer passwords and you have done your first operating as a boss. Each day is stressful and at night you think about everything, planning the next day and challenging yourself. So what is the next hurdle? Well, for me it was my first weekend shift. I had already had some challenges, for instance my first case of primary amenorrhoea (XY with an SRY deletion); my first surgery (a laparoscopic oophorectomy); and my first case of herpes encephalitis in pregnancy (one of 16 written up in the world). In the weekend, I had a spontaneous uterine rupture at 32 weeks, which was definitely a first and will hopefully result in a paper. The reason why the first year is so hard, I think, is because there are so many firsts, but I have got through them with the help and support of my colleagues.

My working week starts on Monday morning at 9am (very civilised) in my private rooms. The length of my clinic work is dependent on the number of patients booked to see me, which is often directly related to how busy my more established colleagues are. I do gynaecology and colposcopy (kindly being lent the use of equipment by my colleagues whilst I become established). Once a month I have a rural clinic, where I travel instead of the patients. This adds diversity to the patients I see, as it is often cheaper to come privately than to take the day off to travel to town (two and a half hours drive each way) and also avoids the need for a day off work. This also gives me the opportunity to spend the weekend mountainbiking or skiing depending on the season. I operate at the private hospital on a Friday with a list which is shared by four specialists, where we all assist each other. I consider patient safety my priority and this has been a fantastic solution to the problem of surgical exposure for me. I assist when I am quiet and I can still book complex surgery, as I have a specialist assistant. Also, I don't share my operating with a registrar!

My hospital job is less clearly defined. I work 0.2 FTE for the hospital, as well as on-call roster. This has had its challenges in balancing workload, but I think I am getting there without annoying my very supportive specialist colleagues too much. I have one antenatal clinic every four weeks and otherwise do a day a week on delivery suite, which is very hands on.

The main job I have is a 0.5 FTE position as a senior lecturer with the university. I love it...mostly. There are stresses that are different from the clinical job and they don't resolve themselves as quickly. It is really like learning a whole new profession. So, after training for 20 years to be a specialist O and G (yes, it did take me that long from starting university), I am back at the beginning again which, as I am in the process of enrolling in a PhD, just proves that I am crazy! If you add up these tenths you will discover there are more than ten, especially if you add administrative time into the equation. At first, I thought this unusual and perhaps foolhardy, however, I have since discovered many of my colleagues work more than ten tenths. This is something to watch out for: jobs expand rapidly. Add in being a training supervisor and perhaps a College examiner and soon you never see your family.

Each job has its advantages and disadvantages. You can cancel a day in private without applying for it and book a conference to the company without filling in 20 request forms, but when your husband breaks his leg you can't just cancel the clinic and theatre list or ask someone else to do them. Public pays you more, but being an academic allows you time to think, investigate and teach of course. Starting a private practice from scratch would be very hard. I have had the fortunate experience of effectively joining a practice. Although we are all individuals and don't cover each other, the support, both in terms of advice and equipment, has been amazing.

I recall a newish consultant when I was a senior house officer telling me the number of days until his retirement; it was said in a voice that was so cheerless that I still remember it. He expected to be in the same job until he retired. My job changes on a day-to-day basis. I can be operating one day and designing a web-based survey the next. I couldn't tell you the number of days until my next holiday, not because I won't get one, but because I have so many things to be excited about before then. So now some advice for those of you starting out: listen to the wise professor and choose your job carefully, because there is more to it than the contract and the roster. For me the people matter.

### RANZCOG Application Aide - TGA Prescriber Status for Mifepristone and Misoprostol

For those seeking to become an authorised prescriber for Mifepristone and Misoprostol, contact RANZCOG for a free application aide:

Nola Jackson  
Women's Health Officer  
(t) +61 3 8415 0408  
(e) njackson@ranzco.org.au

## CPD Self-Education Activities

**Have you been involved in developing or reviewing guidelines and protocols?**

**Did you know you can claim CPD points in the self-education category?**



Download a form from  
the College website at:

[www.ranzco.org.au/fellows/cpdselfeducation.shtml](http://www.ranzco.org.au/fellows/cpdselfeducation.shtml)

If you have been further involved with the implementation and audit of the effectiveness of the guideline/protocol, you can claim this time spent in the PR&CRM category at the rate of one point per hour.



## The Royal Australian and New Zealand College of Obstetricians and Gynaecologists

### **WANTED: VOLUNTEER FACILITATORS FOR RANZCOG BASIC SURGICAL SKILLS WORKSHOPS**

Fellows and Year 5 and 6 Trainees are needed to act as facilitators at the RANZCOG Basic Surgical Skills (BSS) workshops conducted annually in each State in Australia and in New Zealand. Attendance at a BSS workshop is compulsory for all Year 1 RANZCOG Trainees.

These practical, interactive two-day workshops are run on weekends and cover theatre etiquette, handling instruments, knot tying, incision/closure, episiotomy repair, haemostasis, electrocautery and stacks, hysteroscopy and laparoscopy.

Facilitators provide hands-on teaching and advice during the workshop and help with setting up on the day. Time commitment: ONE weekend per year.

*Applications and enquiries: Shaun McCarthy, Training Services Manager  
tel +61 3 9412 2917, fax +61 3 9419 7817, email: smccarthy@ranzco.org.au*

# Urogynaecology and the general gynaecologist



**Dr Kurinji Kannan**  
FRANZCOG  
CU Trainee



**Prof Ajay Rane**  
FRANZCOG CU

**Urogynaecology is the subspecialty in obstetrics and gynaecology that has, in our view, been the most controversial in Australia. Why is it so? Some may think that urogynaecology is nothing but operative pelvic surgery that any Fellow should be able to do.**

Others might think the subspecialty is more about creating a niche market for a select few. Others probably wonder what a subspecialty Fellow does for three years during training if the previous two perceptions are true.

A broad review of urogynaecology-related scientific work reveals significant developments and new directions evolving over the past decade. Urogynaecologists and basic scientists have carried out important research in many areas that drives the subspecialty towards new and useful knowledge. There has been increased focus on cell biology, tissue physiology and biochemistry of the lower urinary tract, in an effort to understand the pathophysiology of the overactive bladder and lower gastrointestinal (GI) tract, and management of associated conditions.<sup>1</sup>

Urethral function has received more interest than ever and

pathophysiological considerations have shifted from the long-held paradigms regarding bladder neck mobility associated with vaginal prolapse in the genesis of stress incontinence.<sup>2</sup> Imaging of pelvic organs made strides in terms of 'what to image', qualitative and quantitative standards for imaging and, more importantly, validity and the predictive value of imaging studies in comparison to existing gold standards of treatment.<sup>3,4</sup> Also, 3D ultrasound scan technology has enabled us to assess mesh behaviour, erosions and failures to some degree, and the field is continuing to evolve. Paradigm changes also occurred in the treatment of interstitial cystitis and the new approach now places emphasis on a more comprehensive approach to bladder pain syndrome (BPS). The concept of anatomical support and creation of fascial planes influenced the development of a variety of surgical procedures and prosthetic (mesh) kits. The advent of mesh kits also resulted in numerous studies and attracted criticisms towards surgeons for lack of rigour in design and analysis.

In our opinion, the Pacific region has also made significant contributions over the decade, with some leading research and inventions related to the field. Professor Zacharin's study of pelvic floor anatomy, Professor Petros' integral theory, the sub-urethral sling procedure and the infracoccygeal sacropexy, were just a few of these contributions. Other major events included the inventions of Perigee and Proxima. Professor Dietz has changed our thinking about visualising pelvic floor structures with ultrasound and his

concepts of levator avulsion.<sup>5</sup> Subspecialty training programs around the world observed these significant developments within the field and incorporated changes to prepare the future workforce.

RANZCOG in Australia revised its certification training program in 2009 and introduced a more detailed curriculum that placed emphasis on program content and rigour. Current subspecialty training programs typically involve two years of extensive training in an accredited unit and an elective year designed by the trainee based on clinical focus and skill requirements of the individual. Entry and successful participation requires a trainee to have long-term interests in the subspecialty and willingness to teach and actively engage in research. Also, participation in an accredited training program often involves relocations and financial decisions due to the nature of training requirements that do not necessarily place the emphasis on competitive incomes for a Fellow. The training units also face increasing scrutiny in terms of quality of the programs provided. RANZCOG requires not just the number of procedures done, but also research output and a 66 per cent pure participation subsequent to certification as a subspecialist.

*'General gynaecologists should be offered training programs that will help them gain a broad understanding of pelvic floor dysfunction encountered in office practice, associated risk factors, appropriate assessment techniques, preventive measures and handling of simple, proven procedures.'*

The fast-paced developments do attract a lot of interest among general specialists who wish to develop special interest in urogynaecology and provide related services as a part of their practice. While such interest is generally well-received, it is emphasised that general specialists be provided with appropriate training that will cover all aspects of treating urogynaecological conditions, such as assessment, investigations, appropriate treatment choices and follow-up of complications; not just learning to perform procedures. The urogynaecology subspecialty, in this regard, faces challenges in the design and development of 'appropriate' training content for specialists who express special interest. As one of the centres that offer 'hands-on training' for specialists in urogynaecological procedures, for us the basic question remains the same. Should we or can we be selective



in training surgeons who are expected to do high volume pelvic reconstructive surgeries as specialists and how do we even define what a high volume is? Once training is completed, how effectively are we monitoring the surgeons for performance and complications? Should we even monitor? To a great degree, industry does seem to play a major role in the development of different kits, choice of kits and a push for training more general specialists in pelvic reconstructive surgery.

While such questions remain, it is also well-acknowledged that general gynaecologists should be offered training programs that will help them gain a broad understanding of pelvic floor dysfunction encountered in office practice, associated risk factors, appropriate assessment techniques, preventive measures and handling of simple, proven procedures. The subspecialty must strive to design and develop training programs that will impart such skills to specialists and evince interest in urogynaecology, while continuing to find and validate new knowledge with the robust application of research principles and framework. One of the purposes of having a subspecialty is to acquire knowledge, specialised expertise and related training in a specific field that will help one provide the best possible care to a patient in need and that approach should provide the context to define the scope of the specialist and the subspecialist. The caveat 'what can the general gynaecologist do' then ceases to exist.

#### References

1. Andersson KE, Arner A. Urinary bladder contraction and relaxation: physiology and pathophysiology. *Physiol Rev.* 2004; 84: 935-986.
2. Kamo I, et al. Functional analysis of active urethral closure mechanisms under sneeze induced stress condition in a rat model of birth trauma. *J Urol.* 2006. 176(6 Pt 1): p 2711-5.
3. Maglinte DD, Kelvin FM, Fitzgerald K, et al. Association of compartment defects in pelvic floor dysfunction. *Am J Roentgenol.* 172:439444, 1999.
4. Dietz HP, Leksukulchai O. Ultrasound assessment of pelvic organ prolapse: the relationship between prolapse severity and symptoms. *Ultrasound Obstet Gynecol.* 2007 Jun; 29(6):688-5.
5. Dietz HP, Lanzarone V. Levator trauma after vaginal delivery. *Obstet Gynecol.* 2005 Oct; 106(4):707-12.

## College ConneXion

Is there an event you'd like to advertise?  
Want to know the latest College news  
or clinical information?

Check out *College ConneXion*,  
RANZCOG's notice board.

Created for all Fellows, Members, Trainees and Diplomates of the College, *College ConneXion* includes courses and professional development opportunities; training and assessment information; workforce updates; and developments in women's health.

[www.ranzcog.edu.au/connexion/index.shtml](http://www.ranzcog.edu.au/connexion/index.shtml)

## Thinking of retiring from active practice?

#### If or when you do retire will you be:

- Completely and permanently retired from practice as a specialist obstetrician and/or gynaecologist?
- No longer acting as an expert witness in the field of obstetrics and gynaecology, except in:
  - cases for which you have already provided an opinion prior to the date of signing this Retirement Declaration; and
  - cases which deal with medical practices current during any time you were in active practice as a specialist obstetrician and/or gynaecologist and prior to signing the Retirement Declaration?

If you answered **YES** to all of the above then why not download the Retirement Declaration form:  
[www.ranzcog.edu.au/fellows/cpdretirement.shtml](http://www.ranzcog.edu.au/fellows/cpdretirement.shtml).

#### What happens to my Fellowship if I sign the Declaration of Retirement form?

If or when you decide to sign and submit the completed Declaration of Retirement form to RANZCOG, your classification will be changed to Retired Fellow.

#### As a Retired Fellow of RANZCOG you will not have to:

- Pay annual subscription fees
- Participate in the RANZCOG CPD Program

#### As a Retired Fellow you will still receive the following from the College:

- *O&G Magazine* (four issues per year)
- *ANZJOG* (six issues per year)
- *Journal of Obstetrics and Gynaecology Research* (if you have elected to receive this)
- *RANZCOG Annual Report*

#### What about my patient records?

See *College Statement No. WPI-8 on Guidelines for Patient Record Management on the Discontinuation of Practice*: [www.ranzcog.edu.au/publications/collegestatements.shtml#WPI](http://www.ranzcog.edu.au/publications/collegestatements.shtml#WPI).

#### What if I don't want to retire just yet?

If you are not in a situation where you can complete the Retirement Declaration form then you will continue as a Fellow of the College.

For further information or a copy of the Retirement Declaration form, please contact:

Val Spark  
CPD Senior Coordinator  
(t) +61 3 9412 2921  
(e) [vspark@ranzcog.edu.au](mailto:vspark@ranzcog.edu.au)

# Postcards from the interface ...between the gynaecologist and the urogynaecologist



**Dr Brett Locker**  
FRANZCOG

## *Wish you were here...*

They say that the only thing unchanging is change itself. Certainly, medical practice changes at a cracking pace. Senior (read, 'older') colleagues of mine reminisce about the age when there were whole nurseries of babies waiting for adoption. When general practitioners managed all the deliveries and only called a specialist as a last resort after many attempts of failed instrumental delivery. And, when hysterectomies were routinely done by your local doctor.

Fast-forward 30 years. It is 1995 and I am at the end of my fourth registrar year and I have done so many caesarean sections that I have stopped counting. My logbook bulges with the details of over 300 hysterectomies and about 200 sacrospinous colpopexies. For all intents and purposes, I am an independent operator for routine gynaecological surgery.

Fast-forward again, only 15 years this time, to the year 2010. The contents of my registrar logbook are the stuff of fantasy now. My registrars at John Hunter Hospital in Newcastle, New South Wales, can only sigh in almost mute anguish at the seeming debasement of their surgical experience. The figures in my logbook are, to them, like the bloated currency of the Weimar Republic in the 1920s, remote and ridiculous.

## *The weather is here, wish you were beautiful...*

The bounty of my surgical experience has been a deep and abiding interest in areas that would be termed 'urogynaecology'. During my time as a trainee and a specialist, the evolution of subspecialty areas has been almost tidal. I believe that the subspecialty of urogynaecology is unique in the degree of overlap that it has with both general gynaecological surgery and advanced endoscopic surgery. How this effects the specialist gynaecologist with 'interests' like mine depends a little on the state in which you practise and whether you work in a regional or metropolitan area.

I began practice as a specialist in regional New South Wales in the wonderful provincial town of Port Macquarie, where I worked for seven years. Times change and now I have settled in a metropolitan hospital (John Hunter Hospital in Newcastle) for the last five years.

There are no surprises when I say that regional practice is commonly broader in its scope than metropolitan practice. The regional or rural practitioner is much more clinically and surgically exposed than his or her city counterpart. I will be provocative and say that, in short, rural and regional areas are often where we need our most clinically experienced specialists.

With the generation of 'baby boomers' retiring for their 'sea change' or 'tree change', the demographic shifts have seen an increasing proportion of urogynaecological cases in these centres, a trend that can only increase. In my regional practice at Port Macquarie, almost two-thirds of my work was of this nature. I could count on one hand the cases I referred for subspecialty opinion.

Newcastle (and associated local government areas) has a population of about 600,000. The area hosts one urogynaecology subspecialist and a total of 20 obstetrics and gynaecology specialists across the public and private sectors. I dare say that the majority practise urogynaecology in significant amounts.

In the Australian state capitals, however, I suspect there are a large number of practising Fellows of RANZCOG with more limited opportunity for gynaecological surgical exposure. Who could blame them for being inclined to refer the limited number of urogynaecological cases they see to a subspecialist?

## *Back to the future...*

We live in an era of medical marketing. Most of us have regular visits from 'representatives' who expound the merits of the latest mesh or the newest sling. As a lure, we are often informed in hushed tones that because 'Dr Wonderful' (it used to be 'Professor Wonderful') is using the mesh, we should use it also. An invitation is issued to a workshop hosted by 'Dr Wonderful', where we are shown the mesh (or sling) *de jour* and told how wonderful the apparatus is and why we should all be using it.

Furthermore, 'Dr Wonderful' gets the endorsement of the International Continence Society, saying that this treatment is the standard of care. To top things off, this treatment is so cutting edge that it is only just in the process of being scientifically appraised, but thankfully for me and 'Dr Wonderful', it has been approved for use on my patients!

May I confess that I find this hard to resist and many of you will know what I mean. Don't we all long to lurk at the cutting edge of something and don't we all want the best for our patients? Forgive me for what I am about to say, but aren't some of us looking for a competitive edge over our rivals? Don't we want our referring general practitioners seeing us as the 'best' doctor for the job?

My repertoire of urogynaecological procedural skills is reasonably broad. Beyond the standard native tissue repairs, I am experienced and comfortable with the use of meshes, sacrospinous hitches, tapes and laparoscopic urogynaecological procedures. I manage re-do surgery. I keep a very close eye on my results and feel reassured that I am offering my patients procedural care of a high standard. Of the few reasons I would refer to a subspecialist, perhaps the most common is when open sacrocolpopexy is indicated.

Yet I consider myself firmly in the camp of the general gynaecologist. I obviously have a strong interest in matters urogynaecological, but don't want to completely limit the scope of my professional life. Variety is indeed the spice...

We should brook no argument that the women we see and treat should be managed in accordance with best practice and their care should be provided by doctors who are experienced and skilled in their field. Ideally, women should have access to such care in the region where they live. Self-evidently, there will be a need and a role for both the subspecialist urogynaecologist and the general gynaecologist with urogynaecology expertise. A challenge for the future is how to train and prepare such practitioners.

My own observations, reinforced in my role as the Integrated Training Program coordinator in my public hospital, confirm the reduced surgical exposure our registrars now commonly experience. There are many factors contributing to this and most are well-known to the readership. If we wish to ensure that women in regional areas are not disadvantaged in accessing urogynaecological skills, training programs must also make provisions such that subspecialist urogynaecological clinics and surgical lists are not the sole domain of the subspecialty Fellow. This is perhaps a matter of fairness in metropolitan areas where Trainees are honed, as it is unreasonable to expect or encourage all prolapse and incontinence surgery be performed by a subspecialist. Indeed, it is a matter of necessity in regional areas that we train our surgical gynaecologists well.

PS...

The inevitable demographic consequences of our aging population mean that there will be an ever-increasing demand for urogynaecological care over time. Such care can be provided by the subspecialist, the endoscopic surgeon or the surgical gynaecologist.

## CPD Points for Past Meetings

**Have you attended a conference and don't know how many CPD points to claim?**

Download the 'point for past meetings' list from the website and check if your meeting is listed.

[www.ranzcog.edu.au/meetingsconferences/pastmeetings.shtml](http://www.ranzcog.edu.au/meetingsconferences/pastmeetings.shtml)

Points for attendance at all RANZCOG accredited meetings are detailed on this list as well as some of the larger overseas meetings.

If you are attending an overseas meeting that is not included on this list please send a copy of the scientific program to:

**Val Spark**

CPD Senior Coordinator

(t) +61 3 9412 2921

(f) +61 3 9419 7817

email: [vspark@ranzcog.edu.au](mailto:vspark@ranzcog.edu.au)



The Royal Australian  
and New Zealand  
College of Obstetricians  
and Gynaecologists

# Trainee Connect



Online Training Resources  
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**Have you changed your address or email account recently?**

**Have you notified the College of these changes?**

If not, please update your contact details via the RANZCOG website ([www.ranzcog.edu.au](http://www.ranzcog.edu.au)) and follow the link to 'Update contact details' or call 03 9417 1699 to notify the College of your changed contact details.



# Some musings on the role of the CREI subspecialist

**Prof Michael Chapman**  
FRANZCOG CREI

**Infertility is a common referral from general practitioners for specialist care. GPs can, and in many cases do, undertake basic investigations of the couple. However, when faced with an abnormal result or, indeed, normal results, infertility treatment remains predominantly in the hands of gynaecologists.**

When referring a couple, whom does the GP select as the appropriate gynaecologist to assist? There are three obvious options. They may refer to their 'mate' to whom they refer all problems gynaecological and obstetric. Or, they may look to the local specialist who has an interest in infertility (and is sometimes associated with an IVF unit). Lastly, they may dash off a note to the gynaecologist with subspecialty training in reproductive endocrinology and infertility.

With the current pressures from couples to achieve pregnancy at the earliest opportunity, it is important that diagnosis and appropriate treatment be instituted in a timely but considered manner. On one hand, the days of prescribing month after month of 'empirical clomiphene,' in the absence of a cause after basic investigation, should be over. On the other hand, recommending IVF as the immediate panacea for all infertility is obviously both premature and at times 'bad medicine'.

Selecting the best way forward for a couple requires experience and training. There is no doubt that a specialist with an interest can provide high quality fertility care. However, the caveats should be that they have had more than the basic exposure to infertility during their training, and that they are keeping up to date with the current evidence for their practice. Keeping up to date necessitates regular attendance at fertility-orientated meetings and reading at least the two or three major fertility journals. Specialists should also be regularly reviewing their practice outcomes.

There are a number of specialists claiming to be 'fertility specialists' whom I have never seen at an infertility conference, like the Fertility Society of Australia annual scientific meeting, nor who are associated with an IVF unit which, by osmosis, at a minimum, provides review and interaction with other specialists in the field.

If specialists with developed skills in infertility can provide appropriate care, what is the point of subspecialisation in infertility? Each of the RANZCOG subspecialty programs aim to produce Fellows with specific skills and expertise beyond that expected for the 'average' Fellow. But what exactly are the skills expected of a subspecialist in reproductive endocrinology and infertility?

The three years of CREI training provide an indepth understanding of the pathophysiology of the full breadth of reproductive endocrine and infertility disorders – far wider than the general gynaecologist will have been experienced. Specific operative skills are equivalent to the general gynaecologist who has developed minimal invasive surgery to an advanced level.

The one common area where a CREI does have unique expertise is andrology. It is only the rare urologist who covers the endocrinology, genetics and treatment of the increasingly common diagnosis of poor semen parameters. With 50 per cent of infertility being

attributed to male factor, the CREI provides the capacity to deal with these affected couples in depth.

The management of ovulation induction requires expertise, both in the selection of treatment regimen and monitoring and the decision to trigger, given the ever present risk of high multiple pregnancy. Subspecialists will have this expertise. Interestingly, there has been a trend towards referral for such treatment to fertility centres with less being undertaken by specialists.

CREI training also prepares them for the management of the more esoteric problems such as intersex and congenital abnormalities. The subspecialist of the future in these areas will almost certainly come through the CREI pathway.

*'The 60 CREI subspecialists in Australia and New Zealand should act as a core resource for standards and leadership in reproductive endocrinology and infertility.'*

Ultimately, by undertaking the demands of CREI, the young gynaecologist is committing themselves to this interesting and exciting area of our specialty. To continue their certification, their practice must predominantly be in the subspecialty and 100 of the 150 points of CPD must relate to the subspecialty.

The other aspect of CREI, both in terms of training and in later practice, is research in the field. When one examines the Australian and New Zealand literature, the majority of recent work related to the clinical aspects of REI involves CREI trainees and their mentors. Given that there are only 20 trainees and 60 subspecialists across Australia and New Zealand, this output positively reflects the philosophy of subspecialisation as a focus for those most interested and skilled in the area to move our knowledge forward and improve standards.

In regard to the issue of best practice, the CREI group now meets on a bi-annual basis and is working on Guidelines for Fertility Practice, which in due course will be open for consultation across all RANZCOG Fellows – specialists and subspecialists alike. It is hoped these consensus documents will improve general infertility care in Australia and New Zealand.

Assisted reproductive treatment in Australia and New Zealand is recognised to be of world standard. Pregnancy rates are as good as anywhere in the world. In Australia and New Zealand, government recognition of infertility as a medical disorder has meant taxpayer funding of its treatment. In Australia, that subsidy has allowed many

hundreds of thousands of couples to access relatively inexpensive care. In excess of 100,000 babies have resulted from IVF alone. This has been achieved against a political backdrop where opposition to IVF and fertility treatments in general continues to be a concern. Our strongest defence has been the rigorous control of ART units through the Reproductive Technology Accreditation Committee.

The ability to demonstrate high standards through external ISO-type auditing against a code of practice developed over the last 25 years makes criticism difficult. At present, the code does not recognise the expertise of CREI subspecialists. It is still possible to be the medical director of an IVF unit as a specialist with little or no experience. Needless to say, the specialists with substantial experience and expertise are keen to maintain the status quo. This debate goes on, with the obvious CREI view that, from a maintenance of standards perspective, directors of fertility units should have the highest credentials.

Overall, it is estimated that some 150 to 180 Fellows are significantly involved in IVF treatment (that is, undertaking more than 100 cycles of treatment per year). Of these, 60 are CREIs. Thus, specialists with expertise in infertility still provide a substantial portion of IVF treatment.

The 60 CREI subspecialists in Australia and New Zealand should act as a core resource for standards and leadership in reproductive endocrinology and infertility. Currently, their geographic distribution is skewed with 80 per cent in Sydney and Melbourne. Recent approvals of training programs in other Australian States should

balance this over time. With infertility affecting one in six couples at some point in their lives, there is no shortage of referrals for specialists and subspecialists alike.

Estimates suggest that, with a population of over 20 million, 1.2 million women will be affected over the 30 reproductive years. There should be 40,000 new cases per year. There is certainly no shortage of work for any of us!

### RANZCOG Application Aide - TGA Prescriber Status for Mifepristone and Misoprostol

For those seeking to become an authorised prescriber for Mifepristone and Misoprostol, contact RANZCOG for a free application aide:

Nola Jackson  
Women's Health Officer  
(t) +61 3 8415 0408  
(e) njackson@ranzcof.edu.au



## Nuchal Translucency Online Learning Program



### **Purpose**

The Nuchal Translucency Online Learning Program (NTOLP) is designed to replace the theoretical course that is conducted for operators who wish to become credentialed to perform Nuchal Translucency scans.

### **Content**

The NTOLP covers eight topics:

1. Principles of screening
2. Practicalities of NT measurement
3. NT and chromosome abnormality
4. Biochemical screening
5. 12-week anomaly scan
6. Screening test results and informed choice
7. Screening and multiple pregnancy
8. Increased NT and normal chromosomes

### **Features**

This site uses many elements to engage and interest the learner. Some examples are:

- Interactivity – mouse over, prediction tasks and multiple choice questions
- Customised images – graphs, detailed diagrams, flash animations and ultrasound scans
- Illustrations and text
- Discussion Forums

The course is now live and costs A\$165.00 incl. GST per individual. Please visit [www.nuchaltrans.edu.au/](http://www.nuchaltrans.edu.au/) for further details or to enrol. This program is co-located with The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) and development has been funded by the Australian Department of Health and Ageing.

# Should the specialist gynaecologist provide a fertility service?

**Dr Joel Bernstein**  
FRANZCOG

**Casting a weather eye over the RANZCOG overview of CREI subspecialists, we gather a number of interesting facts. CREI subspecialists are Fellows of the College who are competent in the comprehensive management of patients with reproductive endocrine disorders and infertility, for example.**

**Dr Jenny Cook**  
FRANZCOG

No great revelation there. These subspecialists should spend about 67 per cent of their clinical time working in their area of the specialty. Hmm...

Well, at least part of their work must be within a professional setting that provides a comprehensive service for patients with infertility or gynaecological endocrine disorders. Hang on, that actually sounds a bit like us. These comprehensive units may be within private or public hospitals. There aren't too many units within public hospitals, so presumably lots of good work is going on in private settings.

And, lastly, the clincher: 'It is not intended that only persons with their CREI should treat infertile couples.' There it is in writing – Fellows who haven't done their CREI are officially allowed to treat infertile couples!

Couples with a fertility delay who live in large metropolitan areas are often well-served with a veritable *carte blanche* of subspecialists upon whom to call. Move away, though, and the choice narrows quickly. Certainly, it might be worth the long drive (or flight) from a provincial centre to seek an opinion, but where does that leave a couple if they need treatment? Driving past a local unit?

Suggesting that only CREI subspecialists should provide higher-level fertility care is, in our opinion, a complete furphy. Were that the case, fertility services would collapse in Australia. Let's find some common ground, though.

The Fellow who is involved in fertility treatment must have some interest in the field to begin with. Fertility management can be a highly specialised area requiring dedication and, unquestionably, additional training and experience. Things change rapidly, so a planned program of ongoing education in the field is important.

Then let's not overlook the fact that the Reproductive Technology Accreditation Committee (RTAC) goes to the trouble of visiting fertility units and carefully reviewing their protocols and results, with a view to ensuring that high standards are met. It is impossible to provide services such as insemination and IVF without being part of such a unit, so there is every incentive to carefully adhere to appropriate standards of care.

Perhaps there is something special about the tests that subspecialists undertake for their patients. Certainly, most specialists can arrange the necessary testing. Should important conditions that require surgery be identified, then a skilled and dedicated endoscopic surgeon is appropriate. The level of surgical expertise required for this mitigates against CREI subspecialists. This could also be said

of the more serious endocrine problems encountered in fertility practice – they are likely better handled by an endocrinologist. The key to good treatment is good cross-specialty relationships and a keen eye for detail.

The basic procedures of IVF, for example, are incredibly simple. Oocyte retrievals and embryo transfers. Even the days of laparoscopic oocyte retrieval or gamete intrafallopian transfer (GIFT) are long gone. The real strengths lie in the embryology expertise available and careful matching of patient to treatment. Therein lies the real challenge.

Like any procedural speciality, continuing confidence comes with regular clinical work. Only when there is a sufficient clinical workload will confidence blossom. And one of the great benefits of working in such a unit is the meticulous review of outcomes – pregnancy rates per transfer, or cycle initiated, or whatever. Don't work in assisted reproduction if you don't like having your results audited and gleefully picked over by your colleagues!

There are a number of other unstated advantages the specialist gynaecologist has over the subspecialist colleagues. Often, there is a longstanding and comfortable relationship, essential when potentially stressful treatment is being contemplated. Particularly in non-metropolitan care, the specialist is also in a position to manage the eventual pregnancy and delivery.

In the end, workforce issues alone mitigate against the nonsense that only CREI subspecialists manage infertility patients. Indeed, the mundane nature of so many cases would surely turn this into a boring toil for such highly-trained practitioners. Having access to subspecialist advice and the facility for tertiary referral for the occasional perplexing case is surely all that is required most of the time. The mere fact that most fertility units have good results in the annual reports and so few of the practitioners are subspecialists, speaks volumes.

The main disadvantages we could think of were that infertility patients might feel uncomfortable sitting in waiting rooms with pregnant women. But they face this risk walking down the street, or in their own workplace.

Let's get real – having CREI subspecialists investigate and manage the majority of couples with a fertility delay is the equivalent of having cancer specialists managing low-grade Pap smears. Enthusiastic Fellows of the College who are working with accredited fertility units, particularly when services are provided to couples with more limited access to tertiary facilities in major urban areas, are the way to go.



# Editor

## The Australian and New Zealand Journal of Obstetrics and Gynaecology (ANZJOG)



ANZJOG is the journal of The Royal Australian and New Zealand College of Obstetricians and Gynaecologists. It is published six times per year, with a print circulation of approximately 5000 to Fellows, Members, Trainees, Diplomates and other members of the College, as well as approximately 300 external subscribers. The journal is also available electronically via Wiley-Blackwell.

As a result of the appointment of the incumbent Professor David Ellwood to the Chair of the Australian Medical Council's Medical School Accreditation Committee, the College is seeking to appoint a suitably qualified person to the position of Editor, commencing in September 2010 with publishing responsibility for the Volume 51 Number 1 issue onwards.

Manuscript submission occurs via the web-based 'Manuscript Central' facility. It is expected that the successful applicant will possess:

- A strong record in scientific/medical research
- Medical qualifications in obstetrics and gynaecology
- Experience in editing and refereeing scientific/medical articles for publication (experience on an editing advisory board would be an advantage)
- Demonstrated management skills in academic and clinical environments
- Good interpersonal and written communication skills
- A commitment to meeting publishing demands and deadlines

Applicants who are invited to interview for the position will be expected to present a well-considered plan for ANZJOG's further development, together with practical ways of achieving it.

The Editor takes responsibility for all editorial aspects of ANZJOG within guidelines set by the ANZJOG Management Committee. This Committee is a standing committee of Council.

A five-year (renewable) contract will be negotiated with the successful applicant.

For further information regarding the position and remuneration package please contact:

Dr Peter White  
Chief Executive Officer  
RANZCOG  
254-260 Albert Street  
East Melbourne  
Victoria 3002, Australia  
(e) [pwhite@ranzcog.edu.au](mailto:pwhite@ranzcog.edu.au)  
(t) +61 3 9417 1699  
(f) +61 3 9419 0672  
(w) [www.ranzcog.edu.au](http://www.ranzcog.edu.au)

Applications should be addressed to Dr Peter White, Chief Executive Officer, RANZCOG, at the above address. Closing date for applications is Friday 30 April 2010, with interviews anticipated to be held in Melbourne in June 2010.

# What does a gynaecological oncologist expect from the specialist gynaecologist?



**Dr Rhonda Farrell**  
FRANZCOG CGO

**As a recently trained gynaecological oncologist, I have always experienced a good professional relationship with other gynaecologists. I see the relationship as a synchronous working partnership based on mutual recognition and respect of each other's different skills, knowledge and caseload.**

It was only after a recent sabbatical trip to France to observe the work of Denis Querleu (an outstanding gynaecological oncologist working in Toulouse) and his colleagues that I made the realisation that this working relationship has not come about by accident, but rather by the forward-thinking and active planning of my Australian colleagues before me.

In France, and indeed in many other European countries, despite the huge advancement in surgical techniques and development of state-of-the-art cancer centres, the development of gynaecological oncology as a recognised subspecialty remains in its infancy. For a number of reasons, there is a reluctance of gynaecologists to refer women with a diagnosis of, or suspicion of cancer.

The women I saw in theatres and on the wards during my visit there were often referred only after they had already had primary surgery with incomplete staging, or no adjuvant treatment, or after their cancer had recurred. The unit itself has established a significant reputation for radical and exenterative-type surgery, but one of the reasons for this was the lack of appropriate screening, optimal surgery or adjuvant treatment for its patients in the first instance. The unit was like a shining pinnacle of a mountain with no foundation.

An historical perspective is necessary to understand how we 'got it right' in Australia. The current relationship that exists in our country between the specialist gynaecologist and the subspecialist gynaecological oncologist began to develop almost 30 years ago. In the early 1980s, it was recognised that the best standard of care for women with gynaecological cancer could realistically only be provided by setting up specialised units, where surgical expertise could be focused and provided within a specialised cancer centre. A number of young gynaecologists were sent to train overseas to learn the expert surgical skills needed to spearhead these units.

On their return, they brought with them not only the surgical expertise and specialised knowledge needed, but also the philosophy of multidisciplinary care that has been the foundation of our current gynaecological cancer centres. Gynaecological oncologists were one of the first surgical craft groups in Australia to introduce regular multidisciplinary 'tumour conferences'. Each week, in each unit in Australia, we meet with our colleagues with expertise in the areas of gynaecological pathology, medical and radiation oncology, palliative care, and specialist nurses and allied

health staff. We discuss each woman diagnosed with cancer, with the aim of developing an integrated treatment plan based on the most current evidence-based treatments. We rely heavily on expert opinions of our colleagues, who themselves could be seen as 'subspecialists' in their own specialties.

All cancer groups have subsequently taken up this philosophy. It is now expected that a woman with breast cancer, or a man with colorectal or prostate cancer, for instance, should receive their surgery and treatment within the framework of similar multidisciplinary care groups. This has been shown not only to improve outcomes for patients with cancer, but allows access to current clinical trials and fosters ongoing clinical research.

*'I believe that one of the most important members of the "team" is the general gynaecologist looking after women in the community.'*

There appears to be rapid changes on the horizon for gynaecological oncology as a subspecialty and although we must be ready and willing to embrace change, we must also be aware of the constant need to prove that such change will improve the survival and quality of life of our patients. Most gynaecological oncologists are now accepting of the expanding role of minimal invasive surgery for the treatment and staging of borderline ovarian tumours, early endometrial cancer and some cervical cancers. Our trainees are now working in endogynaecology units at some time during their training. Most trainees will have developed advanced skills in laparoscopic surgery by the time they have completed their Certification in Gynaecological Oncology (CGO).

Simultaneously, there is a current trend to more radical debulking surgery in women with advanced ovarian cancer. In some units, this means that the gynaecological oncologist is performing difficult upper abdominal surgery such as diaphragmatic stripping, gastrectomy and distal pancreatectomy. This has called for a close working relationship with our colleagues in other surgical disciplines such as upper abdominal or surgical oncology. With this type of radical surgery comes the need for a high level of post-operative care and expertise in caring for critically ill surgical patients. Indeed, it may mean the development of even more 'specialised' subspecialty units, as not all centres may be able to provide this level of care.

Another positive change has been a major shift in terms of addressing aspects of 'survivorship' in our patients. Women treated for cancer have many ongoing problems as a result of the diagnosis and outcome of treatment for their disease. Issues such as loss of fertility, premature menopause, lymphoedema, and social and psychological adjustment are just a few. We are fortunate to work in centres that can provide specialised care for these problems. We have access to physiotherapists, psychologists and social workers with special knowledge and skills. We also have direct links with other subspecialty gynaecologists in the areas of endocrinology, menopause and reproductive medicine to assist us in managing these problems.

So where does that leave us in terms of the future of the relationship between gynaecological oncologists and the 'general' gynaecologist? Any relationship, no matter how functional, can always be improved. I believe gynaecological oncologists should have a greater role in the training of our gynaecologists. In the age of advanced laparoscopic surgery, the opportunity for our trainees to be exposed to the pelvis through an incision greater than a centimetre is likewise getting smaller. Our units must provide positions for gynaecological surgical trainees to develop open surgical techniques. This is not with the intention of creating 'mini' gynaecological oncologists who could then work outside of the current units, but to share our skills with gynaecologists in order that they can perform the more difficult benign procedures and to give them the confidence to convert difficult laparoscopic procedures to less difficult and safer open procedures when the need arises.

I would also like to see gynaecologists sharing a greater role in the follow-up of women after they have been treated for cancer. In most instances, women could have a shared arrangement for follow-up between their own community-based gynaecologist and the oncology unit. This would foster communication between the professional groups and give back to the woman a sense of 'normality' after her treatment.

Complementary to this, the referral basis from our gynaecologist colleagues to the oncology unit could be improved. There are still many women in Australia diagnosed with ovarian malignancy who have not had their primary surgery performed by a gynaecological oncologist. A wider acceptance and use of the Risk of Malignancy Index would mean more appropriate referral of women with an adnexal mass. If in doubt of whether or not to refer, we are only a phone call away and are usually more than willing to give advice when asked.

Secondly, I believe that 'early endometrial cancer', in most situations, is best treated in a gynaecological cancer unit. Most units nowadays will offer laparoscopic hysterectomy with surgical staging, if appropriate. Correct surgical staging may decrease the need for adjuvant radiation, which has its own unique long-term morbidities. Indeed, recognising that persistent 'perimenopausal bleeding' should lead to endometrial biopsy or sampling in the first instance before proceeding to a hysterectomy is a simple rule of thumb.

Lastly and not without some controversy, I believe women who require risk-reducing surgery should be cared for within a multidisciplinary care setting. Although 'risk-reducing BSO' (bilateral salpingo-oophorectomy) is not a difficult surgical procedure by any means, I believe the intense counselling needed, particularly in those young women who have had previous breast cancer or have a BRCA or mismatch repair gene mutation, is best provided in a dedicated unit with strong links to an hereditary cancer clinic, menopause 'after cancer' subspecialist, and other dedicated oncology colleagues.

It is with much interest and optimism that I look forward to continuing my work as a gynaecological oncologist and working with my professional colleagues. It is the 'team' approach to patient care that drew me to this subspecialty in the first place and I believe that one of the most important members of the 'team' is the general gynaecologist looking after women in the community.

I would like to thank Professor Don Marsden and Professor Ian Hammond for their assistance in writing this article.

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# Gynaecological oncology: Where does the non- subspecialist fit in?



**A/Prof Glyn Teale**  
FRANZCOG

*I have opinions of my own, strong opinions, but I don't always agree with them.*

**George W Bush (Former US President)**

Whilst some obstetrician/gynaecologists choose to focus on very narrow aspects of our specialty, others maintain a broader interest. The potential to remain general and all of the skill this requires is a major factor in the popularity of the specialty. Historically, that 'generalism' was reflected in a 'jack-of-all-trades' approach, the gynaecologist undertaking whatever came their way: one day a simple hysterectomy, the next a radical vulvectomy.

by a subspecialist, or in favour of a laparoscopic excision by a general specialist and histological assessment to determine the need for more radical surgery at a later date?

It could be argued that all of these clinically common situations are the domain of the subspecialist. Certainly, in some countries, notably the United Kingdom, that is the trend. The vast majority of the RANZCOG Fellowship is non-subspecialist, with less than three per cent being gynaecological oncologists. Is it practical to have specially trained clinicians operating on women with a low likelihood of malignancy? This may simply preclude women in need of urgent surgery from accessing special skills promptly.

This practice began to change as evidence accumulated that women with ovarian cancer, in particular, have improved survival if operated on by a trained subspecialist – the gynaecological oncologist.<sup>1,2</sup> This realisation led to general acceptance that women suffering from advanced ovarian malignancy should be referred to a gynaecological oncologist.

Particularly for rural patients, transfer to a subspecialist may bring with it substantial inconvenience and psychosocial stress. The cancer centre/cancer unit model adopted in the United Kingdom is probably impractical in Australia, with its distances and differences in practice models. On the other hand, the highly experienced specialist is perhaps on the way out, with concerns expressed over the level of surgical skills of trainees.<sup>7</sup>

The fact that some data show improved outcomes for adequately debulked epithelial ovarian cancer treated by a subspecialist does not necessarily mean all gynaecological malignancies benefit from subspecialist referral. Furthermore, even for ovarian cancer, some data suggest outcomes for women treated by specialists and subspecialists are almost identical in the long-term.<sup>3</sup>

In my opinion, decisions regarding optimal management of a woman with proven or suspected gynaecological malignancy require a practical case-by-case patient-centred approach. The ideal would be for the specialist to be able to discuss the details of an individual woman at a multidisciplinary tumour board. Such review would facilitate an integration of:

Conflict thus exists between these polarised views. On one hand is the expectation that all women with gynaecological malignancy or possible malignancy are referred to the subspecialist. On the other, many non-subspecialists continue to treat women with certain cancers or potential cancers. Determining the most appropriate management within these diverse views is difficult because there remain several areas of uncertainty and controversy:

- Should all women with early endometrial cancer undergo lymphadenectomy when long-term survival may not be improved?<sup>4</sup>
- Should the woman with endometrial hyperplasia with atypia found on sampling also be referred to the subspecialist, given over a 40 per cent chance of concomitant malignancy in some studies?<sup>5</sup>
- What is the best management of the perimenopausal woman with a small complex ovarian cyst, no significant family history and borderline tumour markers? Whilst the likelihood of cancer in such a case is small, the woman's outcome may be worsened if primary surgery is less complete, for example by inclusion of lymph node sampling.<sup>6</sup>
- For the uncertain ovarian cyst, is the balance of risk in favour of radical surgery with pelvic clearance and lymph node sampling

- The skills and experience of the gynaecologist involved
  - It is clearly different if the gynaecologist has 30 years experience with a special interest in oncology, or is three months since elevation to Fellowship with experience of less than ten hysterectomies.
- The social circumstances and wishes of the patient
  - For many patients, the therapeutic relationship with their life-long gynaecologist may outweigh small potential advantages of transfer to a subspecialist.
- The accessibility of a subspecialist
  - The subspecialist may not be able to undertake the hysterectomy for early endometrial cancer for six weeks, when the referring gynaecologist could do it tomorrow.
- The support services available locally
  - Social workers, oncology nurses, etc.
- The clinical details of the case
  - Previous surgery, depth of invasion, obesity, etc.

In some circumstances, there is less room for debate: the morbidity of radical vulvectomy or the need for vascular surgical support clearly favour transfer of women with vulval and cervical cancers, for example. However, the many other areas of controversy require



discussion. Although much effort has been put towards trying to assess likelihood of malignancy using various criteria<sup>8</sup>, these tools fail to take into account the circumstances of the patient.

*'The integrated approach, with easy access to a subspecialist opinion and a pragmatic acceptance by the subspecialist that not all cases need be undertaken by themselves, would serve patients well.'*

A woman with a moderate risk of malignancy index score may ideally be referred, but if she lives 500km away from the nearest subspecialist, that may be impractical. This case may be better dealt with by discussion between specialist and subspecialist, leading to a cohesive plan of management.

The integrated approach, with easy access to a subspecialist opinion and a pragmatic acceptance by the subspecialist that not all cases need be undertaken by themselves, would serve patients well. The gynaecologist wants to be able to discuss the details of the case and receive balanced advice. In return for this consultation, the subspecialist should appropriately triage cases and only take over care where there is a clear advantage to the patient. If transfer is agreed, this should be followed by timely communication about procedures and outcomes.

A patient-centred approach is also required for follow-up. The benefit of follow-up is unclear, but it is often undertaken in the unsubstantiated belief, by patients and clinicians, of improving survival. For most gynaecological cancers, there is little evidence of a survival advantage to regimented follow-up and there are possible negative implications for the woman and her family. Early detection of recurrence may simply mean the woman lives the same amount of time with more of it spent in the knowledge that she is terminally ill! Transfer of the woman back to the referring gynaecologist should be routinely considered. Some patients will feel more reassured by subspecialist review, others won't. Thus the patient's wishes should be taken into account.

On occasions, even if the risk of malignancy seemed low, the gynaecologist may be faced with malignancy in unexpected circumstances: the 30-year-old woman with a torsed ovarian cyst removed laparoscopically that turns out to be malignant, as an example. Unfortunately, when this woman is subsequently referred to the subspecialist, she may be given the impression that the referring specialist 'did the wrong thing'. This sort of criticism seems disappointingly common, is unhelpful and profoundly unprofessional.

In summary, the gynaecologist will continue to be faced with women with gynaecological cancer. Many cancers require transfer to the subspecialist for multidisciplinary team care and advanced surgical skills. There are simply not enough subspecialists, however, to care for all women with cancer or potential cancer. Furthermore, there isn't the evidence in all circumstances that subspecialist care improves outcomes. If the evidence changes in support of all forms of potential or actual cancer benefiting from subspecialist care, routine referral should be supported. Until then, a pragmatic team approach seems to offer the best for our patients.

Conflict of interest: I am a non-subspecialist!

## References

1. Junor EJ, Hole DJ, McNulty L, Mason M, Young J. Specialist gynaecologists and survival outcome in ovarian cancer: a Scottish national study of 1866 patients. *British Journal of Obstetrics and Gynaecology* 1999; 106: 1130-6.
2. Vernooij F, Heintz AP, Witteveen PO, van der Heiden-van der Loo M, Coebergh JW, van der Graaf Y. Specialized care and survival of ovarian cancer patients in the Netherlands: nationwide cohort study. *Journal of the National Cancer Institute* 2008; 100: 399-406.
3. Earle CC, Schrag D, Neville BA, et al. Effect of surgeon specialty on processes of care and outcomes for ovarian cancer patients. *Journal of the National Cancer Institute* 2006; 98: 172-80.
4. Kitchener H, Swart AM, Qian Q, Amos C, Parmar MK. Efficacy of systematic pelvic lymphadenectomy in endometrial cancer (MRC ASTEC trial): a randomised study. *Lancet* 2009; 373: 125-36.
5. Trimble CL, Kauderer J, Zaino R, et al. Concurrent endometrial carcinoma in women with a biopsy diagnosis of atypical endometrial hyperplasia: a Gynecologic Oncology Group study. *Cancer*. 2006; 106: 812-9.
6. Camara O, Sehoul J. Controversies in the management of ovarian cancer – pros and cons for lymph node dissection in ovarian cancer. *Anticancer Research* 2009; 29: 2837-43.
7. Obermair A, Tang A, Charters D, Weaver E, Hammond I. Survey of surgical skills of RANZCOG trainees. *The Australian & New Zealand Journal of Obstetrics & Gynaecology* 2009; 49: 84-92.
8. van den Akker PA, Alders AL, Sniijders MP, et al. Evaluation of the risk of malignancy index in daily clinical management of adnexal masses. *Gynecologic Oncology* 2009.

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# The time to stream the specialty is coming...

**Dr David Molloy**  
FRANZCOG

*'There is one thing stronger than all the armies in the world and that is an idea whose time has come.'*

**Victor Hugo (1802-1885)**

There is an evolution occurring in a gentle but inexorable fashion in O and G. The generalist model is being refined as the academic complexity and skill-base of gynaecology expands. In the capital cities and some major provincial areas, four major types of private practice are evolving. Obstetric group practices with 24/7 in-labour ward coverage are balancing lifestyle demands with the ethical and medico-legal obligations of high standards of care. There are a growing number of office-based gynaecology practices who perform day surgery and procedures such as colposcopy, but refer advanced benign surgery to operative gynaecologists who are mostly laparoscopic surgeons. The collective fourth group is the various subspecialty practices. The rise of the operative gynaecologist represents a significant 'sea change' in our specialty. In recent but past times, busy operative practices were mostly senior gynaecologists, who after half a lifetime of obstetrics honorably retired to surgery, mostly repairing prolapses from an era of vaginal deliveries. Now, many of our seniors reduce their stress by providing expert office consultations and refer their surgery to a younger laparoscopically-trained surgeon.

*'Tomorrow's gynaecological surgeon also needs to be trained in basic urology and general surgery.'*

The time is fast approaching when this trend will need to be formalised in the RANZCOG training program. Procedural colleges such as the College of Surgeons and the College of Physicians have recognised that the one-size-fits-all general degree is now outdated and women's health should be no exception. The many changes in gynaecology surgery of the past 20 years mean that review and restructure of training is becoming urgent. The urgency is because many consultants are becoming alarmed that registrars are struggling to attain sufficient surgical experience during their training to be surgically competent on receiving the Fellowship and entering practice. Many registrars agree and do not have the confidence to begin advanced surgical practice as they finish their training. These concerns have been validated in a recent study by Obermair *et al.*<sup>1</sup>

## **Why are many registrars struggling to get enough operating?**

There are more registrars and fewer lists. Accredited posts have doubled in the past 15 years. In the same period, public hospital operative waiting lists have blown out. Bed numbers have been reduced and operating lists are often cancelled for budget reasons. Productivity has arguably reduced with shorter operating lists, no provision for nursing overtime and an uncertain bed supply up to the day of admission. In Brisbane, the redevelopment of our two

major teaching hospitals meant the loss of 600 beds. Operating theatres were merged, streamlined and reduced. Specialty operating theatres for gynaecology adjacent to the ward were closed. Paid working hours for registrars are less meaning that the shift obligations for labour ward take precedence over gynaecology experience. For example, registrars at a major Melbourne hospital only do 12 weeks of gynaecology in their second training (first registrar) year. There are also more staff specialists who, though generous with their registrars, also need to maintain their skill set and therefore compete for surgery. Changes in the international workforce mean that the high volume operating jobs in places like the UK are no longer available.

Our response to this was first to reduce the logbook numbers for the minimum required number of operations and then to accept that these are often not achieved. Registrars should perform 100 major operations and 50 laparoscopies in four years but often can't achieve even these lowered bars. The operative subspecialties have further shifted surgery away from general specialist training in urogynaecology and oncology. Advanced Fellowships in endoscopic surgery have reduced general specialist opportunities and the higher complexity of this surgery has made supervising consultants more cautious about handing it over to junior registrars. Rural and provincial training opens opportunities, but many provincial specialists worry that the rotational registrars can't use their time to fullest advantage due to their previous lack of operating experience. Private sector training has increased exposure but often not the hands-on for registrars as the primary surgeon.

The first half of the argument for a restructure of surgical training is that the training is no longer able to achieve its objectives in providing enough complex operating to consistently produce a safe and competent gynaecological surgeon in six years. The second half of the argument is that the very nature of gynaecology surgery and practice has changed for the better.

The emergence of endoscopic surgery has been a revolution in improved patient care. Patients have less pain and faster recovery with comparable or fewer complications. It is the mode of surgery we would want for ourselves, our partners and daughters. A well-trained laparoscopic surgeon will nearly never do a laparotomy. The scope of surgery has expanded for conditions such as endometriosis. The proportion of hysterectomies performed laparoscopically has doubled in the last decade rising to 40 per cent in 2008-09. This has required a major but slow reskilling of the surgical workforce. Whilst some consultants were reskilling, it was difficult to teach the registrars. This is another reason for the separation of surgical skills between the emerging group of operative gynaecologists and their contemporaries. Advanced laparoscopic surgery is harder to do, more intricate and requires a greater investment by hospitals in equipment and infrastructure.

A number of specialists have chosen not to reskill and others have never been trained, yet the future is even more complex with the advent of new technologies such as robotics.<sup>2</sup>

There is also less private sector surgery to do. Medicare data (see Table 1) shows that the annual number of benign hysterectomies has dropped by 1000 in the last decade. Each private gynaecologist can now average about six open and four laparoscopic hysterectomies per year. Laparoscopies are down by 4000 to 31,000. Complex laparoscopies for endometriosis have increased to 1700 per year. Adnexal laparotomies are down annually by 1000. Hysteroscopies are up by about 1000, but dilatation and curettages (D&Cs) are down by 8000. Vaginal hysterectomies are down by ten per cent but vaginal repairs have increased (the data is unreliable with the change in item numbers). This is a reduction of 10,000 a year of our most common operations in just ten years, despite record levels of health insurance, a population increase and a struggling public sector. Much of this change is due to better non-operative management of gynaecological conditions. Further reductions are expected in cervical surgery for cervical dysplasia (CIN) and there is a slow shift of procedures to other specialties such as interventional radiology. Importantly, however, there is a shift of care from the operating theatre to the office.

**Table 1. Comparative Medicare data for gynaecology. 2000-01 and 2008-09 financial years.**

	2000-2001	2008-2009
<b>abdominal hysterectomy</b>	8498	5919
<b>vaginal hysterectomy</b>	6015	5558
<b>laparoscopic hysterectomy</b>	2477	3901
<b>total all hysterectomies</b>	16,990	15378
<b>adnexal laparotomy</b>	3264	2316
<b>investigative laparoscopy</b>	22,559	18,285
<b>all advanced laparoscopy</b>	11,024	14,252
<b>investigative hysteroscopy</b>	27819	28711
<b>dilatation and curettage</b>	23129	15018

## The future of gynaecological surgery is fewer, more complex cases, done better.

The time has come to stream the registrars for these evolving career paths. General specialist training could initially involve obstetrics, office gynaecology and basic operative training for day surgery procedures. Probably, in time, obstetrics may hive off as a separate specialty. Complex operative gynaecology and subspecialist streaming should occur at an early stage, probably at the end of second year, reducing the obstetric exposure and maximising access to diminishing resources for surgical training. Surgeons, oncologists and urogynaecologists don't need four years of obstetrics. Tomorrow's gynaecological surgeon also needs to be trained in basic urology and general surgery.

Whilst restructuring the training to reflect reality needs definitive action, the consequences of this would be gradual and non-threatening. The current group of general specialists will not lose their operating, especially those who have upskilled into minimally invasive surgery. However, over time the differential skill-base and referral patterns between graduated operating and office gynaecologists will result in an orderly market. We should not make the same mistakes as happened with the previous introduction of subspecialisation, where insufficient attention was paid to defining the markets for the new qualifications. We need to pay attention

to the political consequences of change as well as the academic requirements. There may be an argument for structuring rebates to ensure the tertiary referral nature of operating gynaecologists, as happens in France. Consultation rebates for office gynaecology may move to those of the physician rather than the proceduralist. It is hard to see any adverse consequences in the public sector which provides both outpatient clinics and operative services.

*'We need proportionately fewer, better trained minimally invasive surgeons. We need more office and procedural gynaecologists.'*

A special sector that does need consideration is the specialist headed for practice in rural and provincial areas. These doctors need to be multiskilled. We will need to continue to train a general specialist group with advanced operating skills to service the country areas. However, this shouldn't be too difficult to implement as it reflects the current training program. In fact, more surgical cases should be freed up for this essential training than are perhaps currently available. Office-based gynaecologists who desire a career change could also have the opportunity to pursue Fellowships in complex surgery and alter their practices.

The proposition to formalise the training of gynaecologists for an advanced surgical qualification is neither radical nor threatening. The trend is happening anyway. The current surgical training is too devolved and uncertain and does not represent best use of diminishing case material and experience. We need proportionately fewer, better trained minimally invasive surgeons. We need more office and procedural gynaecologists. There is a fit, both in the use of training resources and public and private practice. This is evolutionary change that we now need to manage and support.

Dr Molloy has a private practice in infertility and minimally invasive benign surgery. He has been President of the Australasian Gynaecological Endoscopy and Surgery Society (AGES) and the National Association of Specialist Obstetricians and Gynaecologists (NASOG).

## References

1. Obermair A, Tang A, Charters D, Weaver E, Hammond I. Survey of surgical skills of RANZCOG trainees. *ANZJOG*; 49:1; 84-92.
2. Ellwood D. What is the future for gynaecological surgery? Editorial. *ANZJOG*; 49:2; 119.

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# How do urban GPs make decisions about referrals?



**Dr Charlotte Hesse**  
FRACGP

## **How does an urban GP make decisions on whom to refer his/her patients for subspecialty gynaecological problems such as urogynaecology, reproductive medicine and oncology? How does a GP decide between the specialist gynaecologist or a subspecialist?**

There seems to be remarkably little research into why and when an Australian GP chooses to refer a patient to a gynaecologist (specialised or subspecialised). One example of a study concerning gynaecological cancer referrals comes from BEACH (Bettering the Evaluation and Care of Health) data analysis from April 1998 to March 2006.<sup>1</sup>

The analysis looking at gynaecological cancer attendances in general practice in Australia demonstrated that this is an uncommon reason for attendance at a GP, constituting one in 1000 encounters with female patients. Referrals that were designated as being for gynaecological cancer were directed to gynaecologists (specialists) at a rate of 33 per 100 problems. 3.5 per 100 were directed to subspecialist oncologists and 1.5 per 100 to surgeons. The average referral pattern for BEACH is 8.2 per 100 problems. It should also be noted that BEACH only records new referrals, so some patients would have been referred at earlier encounters for the investigation and management of these issues.

*'...the important criterion driving GP referrals...is driven by the communications that occur alongside the referral – before, during and after the consultation.'*

This would have me conclude that, even for an area of highly specialised gynaecological problem, in the first instance, GPs are referring their patients to the gynaecologist of their own personal choice rather than being driven by subspecialisation.

So how do urban GPs, who have ready access to a large database of highly-skilled, competent specialists make decisions concerning the referral of the gynaecological problems of their patients?

I conducted a verbal poll of some of my local urban GPs as to what drives ongoing referrals to specialist gynaecologists versus subspecialist gynaecologists. Twelve out of 15 respondents to this informal gathering of information identified an obvious but frequently overlooked response of most GPs: they respond to good communication from both the specialist and the subspecialist. GPs will refer if they are confident of receiving good letters, feedback that is prompt and personal contact if necessary, whether by phone or email.

This confirms my own personal criterion when selecting a specialist for my patient. Overall, there are nine criteria that guide my decision-making, five of them concerning the communication I can expect or anticipate from the specialist:

1. Timely and relevant information back to the GP regarding the specialist opinion following any consultation, investigation or intervention. This includes information regarding urgent need for hospitalisation or referral on to another specialist for a second opinion.
2. Interactions with the front desk staff/receptionist! This includes both the GP interaction with the frontline phone service and the patient's experience with appointment-making and attendances at the rooms. 'Bulldog' receptionists tend to put off referrers as well as patients. It can be worthwhile trying to access your practice as an outsider to sample an experience!
3. Willingness to communicate with the GP over the phone regarding potential referrals, difficulties with management of current patients under care and/or information about how to manage a patient who may or may not actually need to be referred.
4. Willingness to educate the referrer regarding management of gynaecological problems. Education can occur through detailed letters back to the referrer, but it should be noted that attending GP continuing professional development meetings at the local divisions/networks is an excellent way of both getting to know the GPs personally and demonstrating your personal skills and interests.
5. Internet technologies and computerised files. Although this has not historically featured highly on the list of preferred communication criteria, it should be noted that GPs' patient data management is becoming increasingly computerised. This means that specialists who start to communicate with data files and emails which can be downloaded into patient files (once the issue of embedded secure data is sorted out) will have a 'head start' in winning potential ongoing referrals. Certainly, having good technology helps ensure rapid and smooth communication.

The other criteria, which help in directing referrals, are:

1. Alignment of the patient problem with the gynaecologist's interests and skills. This may or may not mean referring to a subspecialist, but is the only criteria that influences my referral toward the specific skills of the practitioner.
2. Access to services – timeliness and ability for patients that require urgent or semi-urgent attention to be 'fitted in'.
3. Practice geographic catchment zone. Where the consulting rooms are located, ease of access to the rooms, public transport accessibility, and public and private hospital access.



4. Patient demographics, expectations and ability to pay. Bulk billing access when required or access to a flexible method of payment, access to public lists. The patient's personal preference!

Certainly, patient expectations are a strong driving force behind referrals. A study done in London in between 1989 and 1990 by S Webb and M Lloyd looked at 1080 general practice consultations in 12 urban practices. Ten per cent of patients seen were referred on for specialist opinions. Twelve per cent of patients were expecting a referral prior to the consultation. Data analysis stated that if the patient came expecting a referral, they were six times more likely to be referred than otherwise.<sup>2</sup>

However, it would seem that the GP/gynaecologist communication really matters and GPs will make preferences based on their previous experiences of earlier referrals.

Catherine O'Donnell in *Family Practice*, December 2003, performed a literature review around GP referrals. She identified that GP referral patterns vary according to four basic parameters<sup>3</sup>:

1. Patient characteristics
2. Practice characteristics
3. GP characteristics
4. Access to the specialist

Her review also identified that GP referral rate variations could not and did not predict appropriateness or otherwise of the referral. Interestingly, she did not make comment about the importance or otherwise of communication. Perhaps the results of this study reflect the pre-existence of communication patterns between the GP referrer and the specialists, which were taken for granted by the researchers.

In conclusion, the important criterion driving GP referrals does not seem to be related to the subspecialisation of the gynaecologist. Instead, it is driven by the communications that occur alongside the referral – before, during and after the consultation. The general gynaecologist is certainly not an endangered species for the urban GP while these criterion keep being met!

## References

1. Bayram C, Pan Y, Miller G. Gynaecological cancer in Australian general practice. *Australian Family Physician* Vol 36 No 3; March 2007.
2. Webb S, Lloyd M. Prescribing and referral in general practice: a study of patients' expectations and doctors actions. *Br J Gen Pract.* 1994; April 44(381): 165-169.
3. O'Donnell C A. Variation in GP referral rates: what can we learn from the literature? *J Fam. Pract.* 2000; 17: 462-471.

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There are two application types: general awards and travel awards.

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helping to drive research excellence in women's health

# Sexual health medicine

## What is it?



**Dr Darren Russell**  
Director of Sexual Health  
Cairns Sexual Health  
Service

**Sexual health medicine is a relatively new specialty in Australia and New Zealand. In fact, the Australian Minister for Health and Ageing only signed off on our medical specialty status on 8 December 2009. As such, we join a growing list of new medical specialties such as palliative medicine, sports medicine and addiction medicine.**

So, what is this new specialty of sexual health medicine? The Australasian Chapter of Sexual Health Medicine of The Royal Australasian College of Physicians has defined it (in part) as: '...the specialised area of medical practice concerned with healthy sexual relations, including freedom from sexually transmissible infections (STIs), unplanned pregnancy, coercion and physical or psychological discomfort associated with sexuality...

The practice of sexual health medicine encompasses two perspectives: a clinical perspective and a public health approach to sexual health problems.'

We are a small but growing Chapter, currently with 152 Fellows and 19 trainees. On a day-to-day basis, most Fellows in Australia and New Zealand are employed in public settings, usually in sexual health clinics. Most of our clinical time would be spent dealing with STIs, but throughout many parts of Australia, most of the care of people with HIV/AIDS is handled by sexual health physicians. Some Fellows these days also work in the management of hepatitis B and C. In addition, many Fellows work in the field of women's health, particularly reproductive health, but also the management of menopause. Some Fellows also work with those who have been sexually assaulted or with those women with sexual problems such as anorgasmia, vaginismus, vulval pain, chronic pelvic pain and genital dermatoses.

*'The practice of sexual health medicine encompasses two perspectives: a clinical perspective and a public health approach to sexual health problems.'*

Other countries do not seem to have an equivalent to our specialty, although the United Kingdom has GUM (genito-urinary medicine), which is principally concerned with the management of STIs, including HIV/AIDS. Word has it that the specialty of community sexual and reproductive health is set to commence in 2011, which may well have many similarities to our discipline. Continental Europe has dermato-venereology, which is obviously more attuned to the management of genital dermatological conditions. In the United States, on the other hand, our role would be filled by gynaecologists, urologists, infectious diseases physicians, dermatologists, public health physicians, family physicians and maybe even psychiatrists! As such, Australia and New Zealand have broken new ground in having a medical specialty such as sexual

health medicine. We have an excellent curriculum and training program for trainees in the specialty and a range of training posts across the two countries.

Successful training leads to the awarding of the Fellowship of the Australasian Chapter of Sexual Health Medicine (FACHSHM) of the Royal Australasian College of Physicians (RACP). In order to enter the training program, applicants must either hold Fellowship of one of the following Colleges or Faculties:

- Physicians (FRACP) - Adult Internal Medicine or Paediatrics and Child Health
- Dermatology (FACD)
- Obstetrics and Gynaecology (FRANZCOG)
- General Practice (FRACGP and FRNZCGP)
- Pathology (FRCPA)
- Psychiatry (FRANZCP)
- Public Health Medicine (FAFPHM)
- Surgery (FRACS - urology)

In the case of overseas trained specialists (including general practitioners), their qualifications must have been considered equivalent by the relevant Australasian medical college.

Another way to enter our training program is to have completed basic training of the RACP (including success in the FRACP examination). Trainees can expect that training under the supervision of the Chapter will be at least three years. Trainees who hold Fellowship of an approved college may be granted up to 12 months retrospective accreditation if the previous training and experience meets the core requirements of the training program.

A real overlap between some of the work of sexual health physicians and gynaecologists does exist and this would be most readily seen in so-called 'office gynaecology'. Family planning and the medical (as opposed to surgical) management of women's gynaecological health issues (including STIs, vaginal discharge and vulval dermatology) are the most obvious areas of overlap of the two specialties. Some sexual health physicians also perform colposcopies. Our Fellows, however, are physicians, not surgeons, and do not provide surgical management of gynaecological conditions. Nor are we generally involved in the care of pregnant women, except where our input is requested, such as for the management of HIV/AIDS or complicated syphilis during a pregnancy, or in the neonate.

A small number of our Fellows do have dual Fellowships in both sexual health medicine and O and G. This gives these Fellows a unique view of both fields of medicine, with some individuals choosing to maintain their work in both disciplines, in both hospitals and sexual health clinics.

Some Fellows also continue work in general practice, particularly in those practices with high caseloads of individuals with HIV/AIDS.

Some of these Fellows were at the forefront of the battle against HIV in the 1980s, when the extent of this infection (particularly in the homosexual community of Australia) became horribly clear. Many of the patients were already seeing their general practitioners for regular sexual healthcare – syphilis and gonorrhoea being particularly common in the ‘pre-safe sex’ days. These GPs became very skilled in sexual health and were the natural clinicians to deal with the newly emerging AIDS presentations. Some GPs, particularly in the capital cities on the eastern seaboard of Australia, hold dual general practice and sexual health medicine Fellowships and continue to work predominantly in general practice, but with a strong sexual health focus.

The specialty of sexual health medicine has its own journal, *Sexual Health*, published by CSIRO Publishing. It publishes articles of original and significant research on HIV/AIDS, sexually transmissible infections, sexuality and relevant areas of reproductive health. It has grown to become an important journal in its field, with increasing numbers of submissions of a high quality. In addition, two other Fellows and I co-edited a textbook on our specialty, entitled (simply enough) *Sexual Health Medicine*. Its 36 chapters cover the breadth of our discipline, with a slightly expanded second edition now being prepared.

What of the future for sexual health medicine? There seems to be ongoing interest in training posts with our Chapter, so that augurs well. I would personally like to see more training posts in regional areas of Australia and New Zealand, with committed registrar positions in Indigenous sexual health. The sexual health of Aboriginal and Torres Strait Australians, and of New Zealand Maori communities, has a long way to go before catching up with the rest of the populations of our two countries. Dedicated positions in this field could do a lot to improve the situation.

At least two sexual health clinics in Australia have shown strong interest in performing medical abortions in the first trimester. Access to abortion is patchy throughout Australia and almost non-existent in parts of some Territories and States, such as Queensland. A network of sexual health clinics could provide this necessary service using mifepristone and misoprostol, providing that adequate staffing and support were provided. Sexual health physicians have all the necessary skills to take on this task, but would need the back-up of gynaecologists (and possibly GPs) to provide surgical services for the uncommon failures that may occur.

Colposcopy is provided in some parts of Australia by sexual health physicians and this is an area in which many of our trainees wish to gain more experience. Our Fellows are well-placed to provide this service in some sexual health clinics and it would be possible to take on more of the high work-load of this diagnostic and therapeutic intervention. The impact of human papillomavirus vaccination on young women, though, will have effects in the future. There may be less demand for this service in decades to come, as cervical changes due to HPV infection become less common and better testing algorithms utilising DNA testing for HPV infection become more commonplace.

As long as people continue to have sex, in all its combinations, there will be a set of consequences – most of them good, but some of them harmful. Given this, there will always be the need for medical practitioners who deal with the fall-out from sex. Sexual health medicine focuses on the potential and real negative outcomes arising from this most basic of human needs, and tries to assist people to be free of suffering arising from sex. As there is no evidence of people giving up sex at all, those of us working in sexual health medicine are likely to be kept busy for a long time to come!

## Are you planning to survey members of RANZCOG?

**Did you know that your survey must be submitted to the RANZCOG CPD Committee for approval?**

**This process was introduced in June 2000 to regulate the content and number of surveys being sent to the RANZCOG membership.**

**Documentation required by RANZCOG:**

- RANZCOG criteria document detailing your survey
- Final survey
- Letter to be sent to participants with the survey
- Letter to CPD Chair from survey author detailing the purpose of the survey and identifying the class (eg Fellows/ Trainees/Diplomates) of College members that you wish to survey and the location (eg Australia, New Zealand or State).

**RANZCOG requires that a disclaimer (as detailed in the approval letter) be appended to all approved surveys and that the applicant provide feedback of results and copies of any subsequent publications to the CPD Committee.**

**For further information and the survey criteria document please contact:**

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# Family planning



**Dr Christine Read**  
Medical Director  
Family Planning NSW

**Family Planning organisations originated as health and rights-based movements. In the early years of the 20th century, they arose primarily to provide women with contraceptive methods and advice, something that was frowned upon by the community at large and even by medical practitioners.**

Married women (because unmarried women did not have sex!) had to 'be in the know' to prevent unwanted pregnancies by methods other than condoms, withdrawal or abstinence. Family Planning organisations saw themselves not only as healthcare providers, but as advocates for the rights of women.

While the historical development and current structures of the eight State and Territory-based Australian Family Planning organisations have some differences, the organisations share much in their past and present objectives, philosophies and range of services. Family Planning New South Wales started its life in 1926 and was staffed for many years by volunteers and interested medical practitioners. The fitting of the latex diaphragm was the primary woman-centred method in use.

*'... Family Planning organisations continue to take an active role in advocacy for women's health rights.'*

When 'the pill' became available in 1961 in Australia, contraception really became part of mainstream medicine and gynaecologists were at the forefront of its provision. Doctors who worked for Family Planning services in the 1970s were regarded even then as 'playing' at being real doctors, but they had a mission to make 'every baby, a wanted baby'. They were prepared to see unmarried women and also to fight for the rights of women to terminate unwanted pregnancies. This advocacy put them into the role of 'feminists', even though there were a number of passionate men in the Family Planning fold.

Over the years, the politicisation of reproductive medicine has continued and Family Planning organisations continue to take an active role in advocacy for women's health rights. Recent examples include the decriminalisation of abortion law in Victoria; lobbying for the use of RU486 and the subsequent increased availability of medical terminations; and the revision of mandatory reporting requirements in the Northern Territory. Invaluable input is provided into a wide range of national and State policy developments, such as the national women's and men's health policy, and state sexual health and HIV prevention taskforces.

Interestingly, the development of 'the pill' and other hormonal contraceptives opened up a whole new world in medicine. Not only could we manage fertility more proactively, we could also manage a number of common gynaecological conditions, such as menorrhagia and dysmenorrhea, as medical knowledge and clinical experience with the non-contraceptive benefits of hormonal contraceptives grew. This change in the management of bleeding problems led to the need for fewer invasive procedures, such as dilatation/curettage and hysterectomy, and allowed primary care

practitioners to manage conditions that would previously have been referred to a general gynaecologist.

Doctors prescribing the new pill also became proficient at managing the adverse and side effects of hormonal contraceptive methods, with the result that general practitioners often referred patients to Family Planning clinics for advice when their patients experienced problems. Information provision and the management of the consequences of 'risk-taking' behaviour, such as missing pills, unplanned pregnancy, unprotected sexual intercourse and common sexually transmissible infections, became an important element of our work.

## What do Family Planning clinics do today?

Family Planning doctors are usually primary care physicians (often general practitioners in their 'other' lives). Many are Diplomates of RANZCOG and an increasing number are sexual health physicians (Fellows of the Australasian Chapter of Sexual Health Medicine in the RACP). Our clientele is predominantly female, so we are also known as 'women's health' practitioners. We also see men for sexual and reproductive health issues and our services are inclusive of the needs of clients from sexual minorities. We have a team-based ethos and work alongside nurses who, as independent practitioners, have their own patient 'lists', generally managing the 'well woman' and providing invaluable clinical, counselling and educational services. In some States, legislation permits supply of limited medications including ongoing hormonal contraception by 'endorsed' nurses.

The core area of our work is still contraception and since we are designated 'non-government organisations' and receive some government funding, we target our services to disadvantaged communities and people, aiming to complement the work of our colleagues in primary healthcare and gynaecology. Groups for whom we provide tailored information, health education and clinical services in reproductive and sexual health include:

- People from culturally and linguistically diverse (CALD) backgrounds
- Aboriginal and Torres Strait Islander people
- People living with a disability
- Young people
- Same sex attracted and gender diverse people.

Family Planning staff have specific contraception expertise and see women and couples with complex contraception needs, including intercurrent medical conditions or psychosocial issues requiring specific consideration. Apart from standard contraceptive prescription, we also provide 'procedural contraception', therefore, hormonal implant and intra-uterine device insertion and removal. As these long-acting methods that require clinical skills to insert have been developed and introduced to Australia, Family Planning organisations have become training centres for these procedures.

Individual Family Planning organisations have a state-wide charter and although we cannot provide services everywhere, we



take a broad public health approach to preventative healthcare. This includes school and community-based health promotion programs; education programs for doctors, nurses, teachers and allied professionals; and clinical services which integrate all three elements.

An example of this broad approach is the promotion and provision of cervical screening, usually in partnership with other services: the education and upskilling of general practice registrars and practice nurses in taking Pap tests; 'pushing' opportunistic Pap test screening with our clients; and the management of recall systems for abnormal tests. On occasion, we have been congratulated by the local gynaecologist for doggedly following up women who have been thought to be 'lost to follow-up' for their high-grade changes. One State also provides a colposcopy service. Family Planning organisations' expertise in this area has been recognised by State and national cervical screening programs, with representation on key cervical screening advisory groups and being funded to support or provide medical and nursing education in this area.

*'The core area of our work is still contraception and since we are designated "non-government organisations" and receive some government funding, we target our services to disadvantaged communities and people, aiming to complement the work of our colleagues in primary healthcare and gynaecology.'*

In other preventive services, we promote and offer opportunistic chlamydia testing to sexually active young people (25 years and under); screening for other sexually transmissible infections as appropriate; actively promote safe sex; provide preconception advice; and more recently, advocating for, and in some States, administering the HPV vaccine.

Our usual clinical services include 'office' gynaecology such as the management of menstrual problems, pelvic pain and dyspareunia, vaginal discharges, vulval conditions and genital warts. Women and their partners come to us to talk about pregnancy and while we do not provide ongoing antenatal care, we do provide preconception advice, carry out initial antenatal care and initial investigations for fertility problems. We test for and manage most common sexually transmissible infections. However, clients found to be HIV positive are referred to specialised clinics for ongoing management. In addition, many of our doctors have become experts in menopause, especially since general practitioners often appear to be anxious about the management of this area of women's health.

Education and training have become core elements of our work across Australia. One of the Family Planning training doctors in the Northern Territory commented: 'In the Territory, most of the long-standing general practitioners and rural doctors have either been trained or worked within Family Planning Welfare Association of Northern Territory (FPWNT), almost as a professional rite of passage.'

General practice registrars are encouraged to seek family planning training by their supervisors and the General Practice Registrars Association. The delivery of quality services to patients in sexual and reproductive health is acknowledged core business within primary healthcare and the skills required to operate effectively within this community are somewhat different to those developed within hospital-based O and G training formats. The Sexual Health and Family Planning Certificate in Sexual and Reproductive Health, with its competency-based clinical attachment, is recognised as a valuable precursor to this type of practice.

Finally, as organisations with clearly articulated guidelines of practice, based on expert evidence, we are regularly accessed for guidance on management, process and policy. Telephone and web-based information services are provided to both health professionals and the community. Handbooks such as *Contraception: an Australian clinical practice handbook* are published and used by increasing numbers of health professionals nationally.

**More information about Family Planning services can be found at [www.shfpa.org.au](http://www.shfpa.org.au) or on the individual State websites.**

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Are you looking to obtain further PR&CRM points?

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# Preeclampsia and the use of magnesium sulphate

## *A brief review of the literature*

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**Preeclampsia is a multisystem condition characterised by hypertension development (systolic greater than 140mmHg or diastolic greater than 90mmHg) after 20 weeks gestation with greater than 0.3g proteinuria in 24 hours, renal insufficiency, liver disease, neurological problems, haematological disturbances or fetal growth restriction.<sup>6</sup>**

Severe preeclampsia refers to profound hypertension (greater than 160mmHg systolic or greater than 110mmHg diastolic) and extreme organ function derangements. These may involve the nervous system (eclampsia, headache, visual disturbances, hyper-reflexia and clonus); gastrointestinal system (epigastric or right upper quadrant pain, nausea and elevated liver transaminases); haematological system (thrombocytopenia [less than  $100 \times 10^9/l$ ], haemolysis and disseminated intravascular coagulation); or cardiorespiratory problems (pulmonary oedema); acute renal failure; and feto-placental compromise.<sup>4</sup>

*'A Cochrane systematic review incorporating the Magpie Trial and several smaller studies of women with mild, moderate and severe preeclampsia has found that magnesium sulphate halves the risk of eclampsia.'*<sup>10</sup>

Preeclampsia affects five to seven per cent of pregnancies, increases maternal and fetal morbidity, and contributes to 18 per cent of all maternal deaths.<sup>12</sup> Women at increased risk are primigravidas and those with pre-existing diabetes or hypertension, hydatidiform mole, or a family history of hypertension.<sup>14</sup> Most morbidity and mortality is attributable to eclamptic complications.<sup>9</sup> Hence, the benefit of preventing such events is appreciable. Magnesium sulphate is commonly used in preeclampsia to prevent seizures. Dosing regimes established in 1955 remain standard therapy today.<sup>14</sup> However, there is still controversy surrounding which women should be treated and when, and how serum magnesium levels should guide clinical decision-making.

### **Pathophysiology of preeclampsia**

The pathogenesis of preeclampsia is multifactorial and abnormal placentation appears to play a pivotal role. Recent hypotheses propose a two-stage model.<sup>20</sup> First, abnormal placentation involving maladaptation of uterine spiral arteries and failed intervillous space remodelling leads to intermittent placental hypoxia and reoxygenation, predisposing to intrauterine growth retardation (IUGR).<sup>12,14</sup> A preeclamptic placenta may demonstrate degeneration, hyalinisation, calcification and necrosis.<sup>14</sup>

Abnormal placentation is followed by the release of factors into the maternal blood. This produces increased maternal serum soluble fms-like tyrosine kinase 1 (sFlt-1), decreased maternal vascular endothelial growth factor (VEGF), and altered soluble placental growth factor (PlGF).<sup>12</sup> Syncytiotrophoblast microfragments and necrotic trophoblastic material may also be released into the maternal circulation.<sup>20</sup>

The response is then attenuated by numerous maternal factors including diabetes, diet, immunological factors and genetics. However, the relative importance of these is debatable.<sup>20</sup> The end result is maternal vascular changes, including vasoconstriction (producing organ hypoperfusion/ischaemia); breaching of collagen membranes (oedema and proteinuria); and eventual multiple organ dysfunction.<sup>14</sup> Progression to eclampsia is thought to result from this cerebral vasospasm and oedema.

There is further dispute as to when this is initiated. Huppertz<sup>12</sup> suggests that the process begins well before clinical recognition. Early onset preeclampsia represents failed differentiation of all trophoblast cells, extreme fetal hypoxia and IUGR. Later, preeclampsia is associated with failed extravillous trophoblast differentiation leading to the syndrome of preeclampsia, but reduced fetal compromise compared to early onset disease.<sup>12</sup>

### **Mechanism of action of magnesium sulphate**

The exact mechanism of magnesium sulphate in preeclampsia/eclampsia is unknown, however, several theories have been proposed. Firstly, magnesium induces vasodilation by calcium antagonism, decreasing myosin contractility, and promoting tunica media relaxation.<sup>11</sup> It may also act indirectly via the gestationally-dependent production of nitrous oxide, a potent vasodilator, and may inhibit endothelial platelet aggregation via prostaglandin I<sub>2</sub>.<sup>11</sup> Reducing cerebral vasospasm may also prevent eclampsia secondary to cerebral hypertension and oedema, and minimise cerebral ischaemia.<sup>11</sup>

Further, magnesium sulphate may directly reduce cerebral oedema. Calcium antagonism reduces blood-brain-barrier permeability by inhibiting the contraction of cerebral endothelial cells, limiting pinocytosis and inhibiting astrocyte expression of aquaporin-4.<sup>11</sup> Magnesium may also antagonise NMDA (N-methyl-D-aspartate) receptors, decreasing central glutamic stimulation and preventing seizure activity.<sup>11</sup> Furthermore, magnesium sulphate depresses neuromuscular junction transmission, which may reduce external manifestations of seizure activity.<sup>11</sup>

### Evidence for magnesium sulphate in preeclampsia

Several studies have investigated magnesium sulphate for seizure prevention in preeclampsia. Randomised control trials (RCTs) have investigated magnesium sulphate compared to placebo and other anticonvulsants. The largest RCT (n(test)=5055 n(control)=5055), the Magpie Trial<sup>3</sup> investigated preeclamptic/eclamptic women treated with a standard loading and maintenance doses of magnesium sulphate compared to placebo. Women randomised to magnesium sulphate were significantly less likely to experience seizures, and women with eclampsia were less likely to experience recurrent seizures (RR=0.42 95% CI 0.26-0.60). Smaller studies<sup>7</sup> were insufficiently powered to demonstrate significant differences in seizure events. A *Cochrane* systematic review incorporating the Magpie Trial and several smaller studies of women with mild, moderate and severe preeclampsia has found that magnesium sulphate halves the risk of eclampsia.<sup>10</sup>

Magnesium sulphate regimes have also been associated with significantly fewer seizures and recurrent seizures compared to diazepam<sup>10</sup>, nimodipine<sup>5</sup> and phenytoin<sup>10</sup>. However, these were small trials, with limited seizure event numbers.

### Maternal outcomes

Common adverse effects of magnesium sulphate include nausea, vomiting, flushing, hypotension, muscle weakness, paralysis, diplopia, CNS depression and hyporeflexia.<sup>15</sup> Areflexia occurs with total serum magnesium of 8 to 10mmol/l.<sup>11</sup> Life-threatening complications, including renal failure and respiratory paralysis, occur with higher serum magnesium levels (greater than 13mmol/l for respiratory paralysis). Coma, arrhythmias and cardiac arrest may ensue with still higher doses.<sup>11</sup> Overall incidence of magnesium toxicity in women undergoing therapy for preeclampsia is low.<sup>10,3</sup>

Studies analysing mortality in women undergoing magnesium sulphate therapy for preeclampsia have failed to show significant differences in maternal mortality versus controls.<sup>11,3</sup> However, there is a low overall mortality rate in these studies. The Magpie Trial<sup>3</sup> also found no difference between test and control groups for overall maternal morbidity, respiratory depression/arrest, pneumonia, pulmonary oedema, cardiac arrest, renal failure, liver failure, coagulopathy and cerebrovascular events. Risk of placental abruption does not differ significantly with the administration of magnesium sulphate.<sup>16,3,5</sup>

To minimise adverse maternal outcomes, magnesium sulphate therapy should be avoided in women with myasthenia gravis, and concurrent calcium channel blockers administration. Dosage should be modified according to renal function<sup>17</sup> and monitoring should occur routinely as discussed below.

### Perinatal outcomes

Crowther *et al*<sup>8</sup> demonstrated no neonatal adverse effects when magnesium sulphate was given at 30 weeks as neuroprotection for preterm birth. There was also no significant increase in perinatal mortality when the magnesium sulphate was indicated for preeclampsia.<sup>16,7,3</sup> There was no difference in apgar scores lower than seven at five minutes, neonatal respiratory distress, intubation requirements, neonatal hypotonia, or length of special care nursery stay in neonates of women with magnesium sulphate treatment compared to controls.<sup>3,5</sup>

### Practical considerations in magnesium sulphate therapy

Although a standard dosing regime for magnesium sulphate in preventing eclampsia exists, there is debate regarding the appropriate time and clinical situation for the instigating therapy, and how serum magnesium levels should guide decision-making.

Many propose that, given the potential risks of magnesium sulphate, its use is only justified in the presence of severe preeclampsia, not mild preeclampsia, in which baseline seizure risk is low.<sup>21,19</sup> A *Cochrane* review<sup>10</sup> has further suggested that the number needed to treat (NNT) to prevent one seizure is double that for mild preeclampsia compared to severe preeclampsia (100 compared to 50). Additionally, magnesium does not appear to reduce the rate of progression of mild preeclampsia to severe preeclampsia<sup>13</sup>, or gestational hypertension without preeclamptic features to preeclampsia<sup>2</sup>.

Others<sup>17</sup> suggest that a NNT of 100, given the low cost and side effects of magnesium sulphate with appropriate monitoring, justifies its use in all preeclamptics. The Magpie Trial<sup>3</sup> additionally demonstrated that magnesium sulphate consistently reduced relative risk of eclampsia regardless of preeclampsia severity upon treatment initiation. However, this trial relied on subjective clinical judgement to determine eligibility and severity. Additionally, 17 women had experienced seizures prior to recruitment. The use of more objective inclusion criteria would have enhanced the external validity of this study.

*'...following standard regimes, rather than titrating doses against serum magnesium levels, provides the best evidence-based clinical practice.'*

Timing of therapy initiation, in relation to gestational age and labour onset, was also not controlled in the Magpie Trial.<sup>3</sup> Some women were treated antenatally, others 24 hours prior to labour or within 48 hours postpartum, depending on when symptoms were detected. However, a subanalysis of these groups suggested that effects of magnesium sulphate were independent of when therapy was initiated. This reinforces the importance of clinical monitoring in preeclampsia so that therapy can be instigated as new symptoms arise. Similarly, timing of therapy cessation is controversial. Studies have generally found that continuation for 24-48 hours postpartum, followed by appropriate antihypertensive use, is acceptable.<sup>17</sup>

Total serum magnesium is 0.65 to 1.11mmol/l in normal pregnancy, one-third to half of which is protein-bound.<sup>22</sup> Therapeutic range advocated for magnesium sulphate treatment is 2.0 to 3.5mmol/l.<sup>11</sup> However, this estimate was based on a small, retrospective dataset<sup>17</sup> and there are no large-scale trials to support using this range. The Magpie Trial did not measure serum magnesium levels to facilitate blinding.<sup>3</sup> Furthermore, since magnesium sulphate exerts its effects through ionised magnesium, ionised magnesium levels could potentially provide more therapeutic relevance. Indeed, the two indices are poorly correlated.<sup>1</sup> Further research is needed to determine an appropriate monitoring protocol and improve magnesium sulphate safety and efficacy.

Standard regimes (4 to 6mg IV loading dose and 1 to 2mg hourly maintenance dose) do not always raise serum magnesium levels to therapeutic levels. One study concluded that 36.2 per cent of participants undergoing a standard regime achieved 'subtherapeutic' total serum magnesium levels.<sup>1</sup> Despite this, none of these patients developed seizures. However, this study may have been insufficiently powered to detect seizure events. Further, Aali *et al*<sup>1</sup> demonstrated that weight was inversely correlated with serum magnesium levels and suggest that per kilo dosing may be appropriate.

*Continued on page 40.*

However, since side effects are roughly correlated with total serum magnesium levels, serum magnesium monitoring is important. This should be conducted with routine examination of tendon reflexes, respiratory rate and urine output to ensure that magnesium toxicity is detected and treated early.<sup>17</sup>

## Conclusion

There is a long history of magnesium sulphate use in the management of severe preeclampsia and seizure prevention.<sup>9</sup> There is good evidence to support magnesium sulphate therapy over placebo and other anticonvulsants. Magnesium sulphate does not appear to significantly increase maternal or perinatal morbidity or mortality. However, the exact mechanism of action is still unknown. Furthermore, although there is a recommended therapeutic serum magnesium range for preeclampsia therapy, it is well documented that standard regimes often fail to produce these levels. The majority of evidence is based on dosing regimes, rather than attaining these serum magnesium levels. Hence, following standard regimes, rather than titrating doses against serum magnesium levels, provides the best evidence-based clinical practice. Serum magnesium monitoring should still occur for early identification of magnesium toxicity.

Further trials investigating magnesium sulphate efficacy and the effects on both total and ionised magnesium levels are required to increase understanding and perfect clinical guidelines. However, given the current evidence supporting magnesium sulphate in preeclampsia, it may become increasingly difficult, and indeed unethical, to randomise preeclamptic women to placebo. Otherwise, comparing the efficacy and safety of standard regimes to doses titrated against serum magnesium levels would provide clinically useful information. However, these would have to be very large studies, given the relatively few seizure events recorded in women undergoing magnesium sulphate therapy.

## Acknowledgement

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## References

1. Aali BS, Khazaeli P, Ghasemi F. Ionised and total magnesium concentration in patients with severe preeclampsia-eclampsia undergoing magnesium sulphate therapy. *Journal of Obstetric and Gynaecological Research* 2007; 33(2): 138-143.
2. Alexander JM, McIntire DD, Leveno KJ, Cunningham FG. Selective magnesium sulphate prophylaxis for the prevention of eclampsia in women with gestational hypertension. *Obstetrics and Gynaecology* 2006; 108: 826.
3. Altman D, Carroi G, Dudley L, et al. Do women with preeclampsia, and their babies, benefit from magnesium sulphate? The Magpie Trial: a randomised placebo-controlled trial. *Lancet* 2002; 359: 1877-1890.
4. Australian and New Zealand College of Anaesthetists (ANZCA). *Management of preeclampsia and eclampsia*. [Electronic]. 2008. Retrieved 30 May 2009 from [www.anzca.edu.au](http://www.anzca.edu.au).
5. Belfort MA, Anthony J, Saade GR, Allen JC, for the Nimodipine Study Group. A comparison of magnesium sulfate and nimodipine for the prevention of eclampsia. *New England Journal of Medicine* 2003; 348:304-11.
6. Brown M, Hague WM, Lowe S, McCowan L, Oats J, Peek MJ, Rowan JA, Walters BN. The detection, investigation and management of hypertension in pregnancy: Full consensus statement. *The Australian and New Zealand Journal of Obstetrics and Gynaecology* 2000; (40): 139-155.
7. Coetzee E, Dommissie J, Anthony J. A randomised controlled trial of intravenous magnesium sulfate versus placebo in the management of women with severe preeclampsia. *British Journal of Obstetrics and Gynaecology* 1998; 105:300-303.
8. Crowther CA, Hiller JE, Doyle LW, Haslam RR, for the Australasian Collaborative Trial of Magnesium Sulfate (ACTOMgso4) Collaborative Group. Effect of magnesium sulfate given for neuroprotection before preterm birth. A randomised controlled trial. *JAMA* 2003; 290:2669-2676.
9. Cunningham FG, Leveno KL, Bloom SL, Hauth JC, Gilstrap LC III, Wenstrom KD. 'Chapter 24: Hypertensive disorders in pregnancy' In Cunningham FG, Leveno KL, Bloom SL, Hauth JC, Gilstrap LC III, Wenstrom KD. *Williams Obstetrics*, 22nd Edition. [Electronic]. Retrieved 7 June 2009 from <http://info.library.unsw.edu.au/cgi-bin/local/access/access.cgi?url=http://www.accessmedicine.com/textbooks.aspx>.
10. Dudley L, Gülmezoglu AM, Henderson-Smart DJ. Magnesium sulphate and other anticonvulsants for women with preeclampsia. *Cochrane Database of Systematic Reviews* 2003; Iss.2 Art No. CD000025. DOI: 10.1002/14651858.CD000025.
11. Euser AG, Cipolla MJ. Magnesium sulfate for the treatment of eclampsia: A brief review. *Stroke* 2009; 40: 1169-1175.
12. Huppertz B. Placental origins of preeclampsia: Challenging the current hypothesis. *Hypertension* 2008; 51: 970-975.
13. Livingstone JC, Livingstone LW, Ramsey R. Magnesium sulphate in women with mild preeclampsia: a randomised controlled trial. *Obstetrics and Gynaecology* 2003; 101:217.
14. Purcell K J, Lingappa V R, Taylor RN. "Chapter 22. Disorders of the Female Reproductive Tract" In McPhee SJ, Ganong WF. *Pathophysiology of Disease*, 5th Edition 2006. [Electronic] retrieved 03.06.09 from [www.accessmedicine.com/content.aspx?alD=2091477](http://www.accessmedicine.com/content.aspx?alD=2091477).
15. MIMs 2009. MIMs online: Prescribing information: DBL magnesium sulphate concentrate injection. [Electronic]. Retrieved 07.06.09 from [http://mims.hcn.net.au.viviana.library.unsw.edu.au/ifmx-nsapi/mims-data/?Mlval=2MIMS\\_abbr\\_pi&product\\_code=3772&product\\_name=DBL+Magnesium+Sulfate+Concentrated+Injection](http://mims.hcn.net.au.viviana.library.unsw.edu.au/ifmx-nsapi/mims-data/?Mlval=2MIMS_abbr_pi&product_code=3772&product_name=DBL+Magnesium+Sulfate+Concentrated+Injection).
16. Moodley J, Moodley V. Prophylactic anticonvulsant therapy in hypertensive crises of pregnancy: The need for a large, randomised trial. *Hypertension in Pregnancy* 1994; 13:245-52.
17. Norwitz ER, Repke JT. 'Management of Preeclampsia' In *Up-To-Date* 2009. [Electronic] Retrieved 05.06.09 from [www.uptodate.com](http://www.uptodate.com)
18. Redman CWG, Sargent IL. Placental stress and preeclampsia. *Trophoblast Research* 2009; 23: S38-S42.
19. Rosenberg P. Magnesium sulphate prophylaxis in preeclampsia. *Gynécologie, Obstétricitet Fertilité* 2006; 34:54-59.
20. Roberts JM, Hubel CM. The two-stage model of preeclampsia: Variations on a theme. *Placenta*. 23(Supp A):S32-S37.
21. Sibai BM. Magnesium sulphate prophylaxis in preeclampsia: lessons learned from recent trials. *American Journal of Obstetrics and Gynaecology* 2004; 190:1520-1525.
22. Sukonpan K, Phupong V. Serum calcium and serum magnesium in normal and preeclamptic pregnancy. *Archives of Gynaecology and Obstetrics* 2005; 273(1):12-16.
23. Yoshida M, Matsude Y, Akizawa Y, Ono E, Ohta H. Serum ionized magnesium during magnesium sulfate administration for preterm labour and preeclampsia. *European Journal of Obstetrics and Gynaecology and Reproductive Biology* 2006; 128: 125-128.

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# The ties that bind us: the nuchal cord



**Dr Carol Portmann**  
FRANZCOG

## What should an obstetrician do when nuchal cord is reported on an ultrasound late in pregnancy?

Google 'nuchal cord' at your own risk. You will be taken to many informative sites, but you will also be exposed to the internet pregnancy forum and many more anti-medical, often biased and potentially misleading opinions. But are we being equally biased in our response to some of the lay (and medical) opinions expressed on the web? Have we allowed the nuchal cord to become a noose around our necks (...sorry) thereby over reacting to a natural fetal event or have we ignored a serious issue?

Hippocrates described nuchal and chest coiling of the umbilical cord as: 'One of the great dangers of the eighth month'. He also stated that persistence of the nuchal cord 'will cause suffering to the mother and either perish or born difficulties to the fetus'.<sup>1</sup> More recently, in 1750, William Smellie described a stillborn with four nuchal loops<sup>2</sup>; and in 1769, Andrew Bell published a drawing in the *Encyclopedia Britannica* depicting a fetal death with one nuchal cord, a body loop and a true knot.<sup>3</sup>

*'Ultrasound can distinguish between single and multiple nuchal loops, but cannot reliably identify tight nuchal cord.'*<sup>18</sup>

In 2010, then, what are the important questions we must ask and answer regarding nuchal cord? I propose the following questions:

1. Does nuchal cord predispose to significant, persistent neonatal morbidity and perinatal mortality?
2. Should the presence of nuchal cord be examined for when performing third trimester ultrasound and should its presence be reported?

Leading finally to the most challenging question of all:

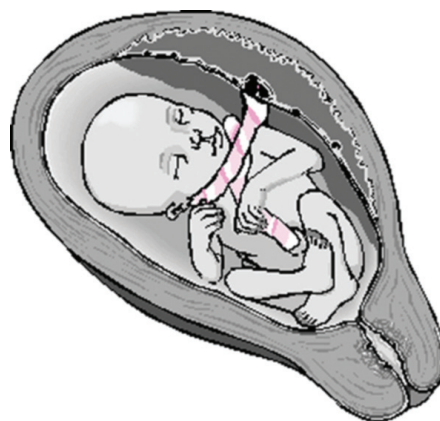
3. Does antenatally identified nuchal cord require obstetric intervention?

### Background

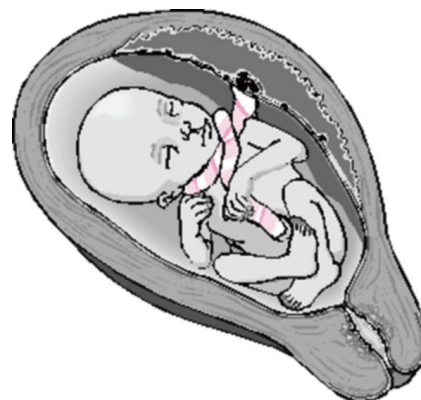
The definition of nuchal cord (NC) – 'the condition in which the umbilical cord is wound at least once around the neck of the fetus' – is attributed to Dr J Selwyn Crawford, a British obstetric anaesthetist, in 1962.<sup>4</sup> In studies of 468 babies with nuchal cord, he remarks that there is an increased liability to neonatal depression.<sup>5</sup> Prior to this, Shui's study of 1000 consecutive deliveries in 1957 did not find any correlation with perinatal mortality and the presence of a single NC.<sup>6</sup> The question of the significance of NC has persisted since that time.

In 1988, Giacomello described two types of NC, in relationship to breech presentation<sup>7</sup>:

- Type A – nuchal loop that encircles the neck in a freely sliding pattern.



- Type B – nuchal loop that encircles the neck in a locked pattern.



*Reprinted with permission from TheFetus.net, Ultrasound diagnosis of quintuple nuchal cord entanglement and fetal stress, Silva et al.*

The significance of this differentiation is that type B cord loops may result in true knots in the cord, should the fetal body slip through the 'noose'. Collins observed that the type B pattern occurred in one in 50 births and that operative delivery and stillbirth were more common with this type of NC.<sup>8</sup>

Many others further differentiate NC presentations as loose versus tight and single versus multiple in an attempt to potentially identify and record the 'pathological' NC. A loose NC can easily be uncoiled before delivery of the fetal trunk. The NC is considered tight when it requires clamping and cutting before delivery of the trunk.<sup>9</sup>

### Natural history

NC is found in 20 per cent of babies at delivery (range 15 to 34 per cent).<sup>4,5,6,10,11</sup> The majority are single loops, with double loops found in 1.7 to 3.8 per cent and three or more loops in 0.2 to 0.3 per cent.<sup>6,12,13</sup> Twenty-five percent of cord loops are tight, though this figure is higher for multiple loops (60 per cent).<sup>9</sup>

Prospective studies through pregnancy using ultrasound indicate that NC can resolve and recur throughout pregnancy. However, the later they are noted in pregnancy, the more likely they are to persist to term.<sup>12,14,15</sup> In studies by Lal<sup>14</sup>, Larson<sup>12</sup> and Clapp<sup>15</sup> the incidence of NC was six per cent at 20 weeks; 7.5 per cent to 15 per cent at 30 weeks; 25 per cent at 36 to 38 weeks; and 28 to 37 per cent at birth. Lal found that of those fetuses with NC at 36 to 38 weeks, 85 per cent persisted until delivery. Clapp found that 60 per cent of fetuses had a NC identified at some time during pregnancy, with only 25 per cent persisting for more than four weeks.

The sensitivity of colour Doppler ultrasound in detecting NC has been reported to range from 38 per cent to 96 per cent and the positive predictive value between 30 to 82 per cent.<sup>16,17,18</sup> Ultrasound can distinguish between single and multiple nuchal loops, but cannot reliably identify tight NC.<sup>18</sup>

### Outcomes

Somewhat disparate findings regarding obstetric/antenatal associations and outcomes of NC have been reported over the past 40 years. The presence of NC at delivery is not associated with increased perinatal mortality, but has been reported by some to be associated with increased incidence of fetal CTG abnormalities (consistent); meconium stained liquor (inconsistent); low APGAR scores; umbilical artery acidosis (inconsistent); operative delivery in nulliparas; IUGR (inconsistent); neonatal resuscitation; admission to NICU; and neonatal anaemia and cerebral palsy, with varying degrees of significance.<sup>4-6,9-11,15,17,19,20-28</sup> The overall conclusion of these studies is that NC identified at delivery is not associated with significant, persistent adverse perinatal outcomes.

The presence of NC on ultrasound does not appear to be associated with increased perinatal mortality<sup>15,19,21</sup>, however, studies to date have not had the power to address this question, as the

approximate rate of NC associated stillbirth would be approximately 0.2 to 0.27 per 1000 births or one in 3700 to 5000 births (excluding true knots and other 'cord accidents').<sup>3</sup>

In a prospective blinded study, examining 84 fetuses through pregnancy and delivery, Clapp found no significant difference between outcomes in the NC group and controls, other than an increased incidence of fetal heart rate abnormalities in labour in the NC group.<sup>15</sup> Interestingly, persistence of antenatal NC for later than four weeks was associated with a 75 per cent incidence of asymmetric growth restriction, and though CTG monitoring was normal, these babies also demonstrated some cerebral blood flow distribution. In a prior retrospective study, Clapp made a similar observation regarding persistence of antenatal NC and mild growth restriction. In that study, it was found that multiple nuchal loops, tight cord at delivery, symptomatic NC in labour (fetal heart rate abnormalities with or without meconium), and antenatal persistence of NC, were significantly associated with subclinical deficits in neurodevelopmental scores at one year of age. These differences were not seen in babies with no NC or incidental NC (uncomplicated labour and delivery). Clapp's conclusion was: 'There may be a continuum in outcome following NC ranging from an entirely normal short and long-term outcome through a variety of short-term morbidities and minor subclinical deficits in development to the extremes of intrauterine demise or spastic quadriplegia.'<sup>20</sup>

The pathology of NC may be related to acute, chronic or intermittent cord compression, resulting in fetal hypoxia, biochemical derangements and circulatory shunting. It is postulated that length of cord; position of placenta and cord insertion relative to the fetus; number, type and tightness of nuchal loops; coiling and relative thinness of cord; presence of cord knots or truncal loops; and abnormal fetal movements may all interact to predispose to pathological cord compression and adverse outcome.<sup>3,20</sup>

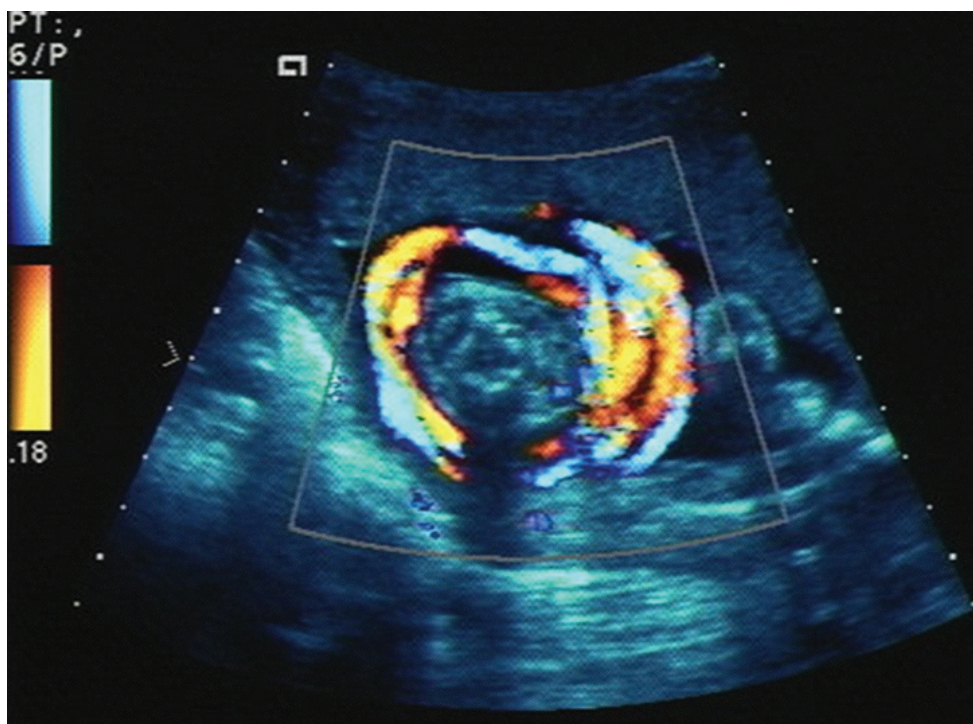
### Management of the antenatally identified nuchal cord

Is there evidence to suggest that ultrasound assessment for the presence of NC should be part of routine ultrasound scanning or antenatal care? No. The presence of NC alone is unhelpful in predicting the fetus at risk of significant cord compression and ultrasound (at this time) has been unable to identify additional markers of concern other than multiple nuchal loops. Therefore, routine assessment for NC prior to delivery is of no benefit.

However, it is common practice for sonographers to note the presence/absence of NC when imaging the breech fetus prior to external cephalic version (ECV) or planned vaginal delivery. NC is considered by some to be a relative contraindication for ECV, though the evidence for this is lacking.<sup>30</sup> Likewise, if NC is identified when imaging for other indications in the third trimester, it is not uncommon for this to be noted by the sonographer and the reporting radiologist.

The dilemma then, is what to tell the mother and whether further monitoring or other management is required.

*Continued on page 44.*



Reprinted with permission from *obgyn.net*: Nuchal Cord by: Mario Ernesto Libardi.

It is reasonable care to inform your patient that the ultrasound has identified a NC and to discuss the limitations of ultrasound, the common occurrence of NC and the chance that it may resolve before delivery. Advise the woman to monitor fetal movements and report unusual increases and decreases in fetal activity.

Increased monitoring for simple NC remote from term does not appear to be indicated.<sup>21</sup>

Induction of labour for single NC is not indicated in the absence of other indications. Caesarean section is not indicated in the absence of fetal concerns or compromise.

The management of multiple NC is less certain, but again, vaginal delivery at term is not contraindicated. Fetal heart rate monitoring in early labour is suggested. There is no clear indication for elective caesarean section, but this is at the discretion of the treating obstetrician and the mother, given the evidence in some studies of greater risk of meconium, abnormal fetal heart rate pattern, operative vaginal delivery and mild umbilical artery acidosis at birth with multiple NC.<sup>29</sup>

Further studies are required to identify the antenatal factors associated with NC that increase the likelihood of significant adverse outcome and what obstetric interventions (if any) will prevent adverse outcome.

### References

1. Hippocrates: *De Octimestri Partu*.
2. Smellie W. *A Treatise on the Theory and Practice of Midwifery*. Volume 1, 1752.
3. Collins JH. *Umbilical Cord Accidents 2010*. Available from: [www.preginst.com/](http://www.preginst.com/).
4. Crawford JS. Cord round the neck. Incidence and sequelae. *Acta Paediatr*. 1962; 51:594.
5. Crawford JS. unpublished data referenced in comments in *BMJ*; 17 October 1964.
6. Shui KP, Eastman NJ. Coiling of the umbilical cord around the fetal neck. *Br J Obstet Gynaecol*. 1957;64:227-9.
7. Giacomello F. Ultrasound determination of nuchal cord breech presentation. *Am J Obstet Gynecol*. 1988; 159:531-2.
8. Collins JH. Nuchal cord type A and type B. *Am J Obstet Gynecol*. 1997; 177(1): 94.
9. Shrestha NS. Nuchal cord and perinatal outcome. *Kathmandu University Medical Journal* 2007; 5 (3):360-363.
10. Ghosh GS. Nuchal cord in post-term pregnancy – relationship to suspected intrapartum fetal distress indicating operative intervention. *J Perinat Med*. 2008;36(2):142-4.
11. Sheiner E, et al. Nuchal cord is not associated with adverse perinatal outcome. *Arch Gynecol Obstet*. 2006; 274: 81-83.
12. Larson JD, Rayburn WF, Harlan VL. Nuchal cord entanglements and gestational age. *Am J Perinatol*. 1997; 14(9):555-7.
13. Carey JC, Rayburn WF. Nuchal cord encirclements and birth weight. *J Reprod Med*. 2003; 48(6):460-2.
14. Lal N, et al. Does the nuchal cord persist? An ultrasound and color-Doppler-based prospective study. *J Obstet Gynaecol Res*. 2008; 34(3):314-7.
15. Clapp JF. The natural history of nuchal cords. *Am J Obstet Gynecol*. 2003; 189:488-93.
16. Aksoy U. Prenatal color Doppler sonographic evaluation of nuchal encirclement by the umbilical cord. *J Clin Ultrasound*. 2003; 31(9):473-7.
17. Peregrine E, et al. Ultrasound detection of nuchal cord prior to labor induction and the risk of Cesarean section. *Ultrasound Obstet Gynecol*. 2005; 25(2):160-4.
18. Qin Y, et al. Color ultrasonography: a useful technique in the identification of nuchal cord during labor. *Ultrasound Obstet Gynecol*. 2000 May; 15(5):413-7.
19. Assimakopoulos E, et al. Nuchal cord detected by ultrasound at term is associated with mode of delivery and perinatal outcome. *Eur J Obstet Gynecol Reprod Biol*. 2005; 123(2):188-92.
20. Clapp JF, et al. Nuchal cord and neurodevelopmental performance at one year. *Am J Obstet Gynecol*. 2003; 189(2):488-93.
21. González-Quintero VH, et al. Outcomes of pregnancies with sonographically detected nuchal cords remote from delivery. *J Ultrasound Med*. 2004; 23(1):43-7.
22. Jauniaux E. Perinatal features of pregnancies complicated by nuchal cord. *Am J Perinatol*. 1995; 12(4):255-8.
23. Martin GC. Acidosis in newborns with nuchal cords and normal Apgar scores. *J Perinatol*. 2005; 25(3):162-5.
24. Mastrobattista JM, et al. Effects of nuchal cord on birthweight and immediate neonatal outcomes. *Am J Perinatol*. 2005; 22(2):83-5.
25. Miser WF. Outcome of infants born with nuchal cords. *Journal of Family Practice* 1992.
26. Nelson KB, et al. Potentially asphyxiating conditions and spastic cerebral palsy in infants of normal birth weight. *Am J Obstet Gynecol*. 1998; 179(2):507-13.

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For those holders of the DRANZCOG and DRANZCOG Advanced due to recertify this triennium, time is running out. If your Diploma certificate has an end date of **31 December 2010**, you have a recertification requirement in the current triennium and must obtain a total of **40 Category 1 points** in Women's Reproductive Health activities before **31 December 2010**.

#### **Where to find activities**

The list of Women's Reproductive Health activities can be found on the Meetings Calendar in the latest issue of *O&G Magazine* or on the RANZCOG website: [www.ranzcog.edu.au/meetingsconferences/index.shtml](http://www.ranzcog.edu.au/meetingsconferences/index.shtml)



# Q&A

*Q&A* attempts to provide balanced answers to those curly-yet-common questions in obstetrics and gynaecology for the broader *O&G Magazine* readership including Diplomates, Trainees, medical students and other health professionals.

## Q What advice would you give a 55-year-old woman with low libido?

**Dr Sonia Davison**

FRACP

Alfred Hospital, Monash University

**a** The first thing to do is to determine whether the low libido is distressing the woman<sup>1,2</sup> and whether this situation is new or long-standing. Another essential factor is whether the woman otherwise has a good relationship with her partner and if she still finds him/her attractive. A careful assessment of mood is important to exclude depression or anxiety.<sup>3</sup> Assess the woman's general health; does she have significant co-morbidities that may be causing secondary lowered libido? Assessment of medication use may reveal potential inhibitors of libido, such as SSRI (selective serotonin reuptake inhibitors) anti-depressant use.<sup>4</sup> Examples of important pathologies to exclude: anaemia, iron deficiency and thyroid dysfunction.

A general screen for sources of stress is important, including financial, family, job, or other factors. Is libido hampered by the presence of teenagers or adult children still living at home? Is the woman too tired in general to be bothered with intimacy? Ask if libido improves whilst on holiday, on romantic getaways, or when children are absent from home.

A careful assessment for the sequelae of estrogen deficiency should be made, asking about the presence of vaginal dryness, dyspareunia and current strategies used to address these problems, if present. Does she have any other genito-urinary or vasomotor symptoms? Is she sleep-deprived due to persistent hot flushes or night sweats? Does she have any other symptoms suggestive of androgen deficiency, such as amotivation, lowered mood or persistent fatigue?<sup>5</sup>

Management should be targeted to the likely cause and may include counselling, alternative anti-depressant use, stress reduction techniques, etc. If the woman is otherwise healthy, has a good relationship with her partner and the most likely cause is menopause-related estrogen deficiency, then reasonable options include regular use of Replens or vaginal estrogen if genito-urinary symptoms predominate, and a trial of systemic estrogen

and progestin-based HRT (the latter essential in those with intact uterus), if genito-urinary and vasomotor symptoms co-exist. If symptoms suggestive of androgen deficiency are present and serum testosterone levels are low/low-normal, the woman may benefit from a trial of testosterone treatment.<sup>6,7</sup>

Female sexual dysfunction is an evolving area of women's health. Participation in a research study may offer the woman an option for exploring treatment strategies. The Australasian Menopause Society website ([www.menopause.org.au](http://www.menopause.org.au)) lists studies that are currently recruiting.

### References

1. *Diagnostic and statistical manual of mental disorders: DSM-IV-TR*. 4th edition; text revision ed. Washington, DC: American Psychiatric Association; 2000.
2. Leiblum SR, Koochaki PE, Rodenberg CA, Barton IP, Rosen RC. Hypoactive sexual desire disorder in postmenopausal women: US results from the Women's International Study of Health and Sexuality (WISHeS). *Menopause* 2006; 13(1):46-56.
3. Davison SL, Bell RJ, LaChina M, Holden SL, Davis SR. The relationship between self-reported sexual satisfaction and general well-being in women. *J Sex Med*. 2009; 6(10):2690-7.
4. Montejo AL, Llorca G, Izquierdo JA, Rico-Villademoros F. Incidence of sexual dysfunction associated with antidepressant agents: a prospective multicenter study of 1022 outpatients. Spanish Working Group for the Study of Psychotropic-Related Sexual Dysfunction. *J Clin Psychiatry* 2001; 62 Suppl 3:10-21.
5. Bachmann G, Bancroft J, Braunstein G, et al. Female androgen insufficiency: the Princeton consensus statement on definition, classification, and assessment. *Fertil Steril*. 2002; 77(4):660-5.
6. The role of testosterone therapy in postmenopausal women: position statement of The North American Menopause Society. *Menopause* 2005; 12(5):496-511; quiz 649.
7. Wierman ME, Basson R, Davis SR, et al. Androgen therapy in women: an Endocrine Society Clinical Practice guideline. *J Clin Endocrinol Metab*. 2006; 91(10):3697-710.

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**Please send entries to *Q&A* @ *O&G Magazine* via:**

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# How can I become a better gynaecologist/obstetrician?

**Prof Andreas Obermair**  
FRANZCOG

**'How many hysterectomies did I do last year? How many of those were laparoscopic? How does my complication rate compare to others?' Prompt and reliable answers to those questions are crucial to gynaecologists interested in further developing their surgery and also form the basis of enhancing every gynaecologist's surgical skills.**

If you don't know what your conversion or complication rate is, how could you possibly improve it?

Clinical audit is a technique to receive feedback about outcomes from treatment. In order to maximise its learning effect on surgeons, feedback needs to be measurable, very specific and delivered in a non-threatening way. This is much more helpful than 'feedback' that we often receive from well-meaning colleagues, such as: 'I am not surprised that you had to convert this operation to open.'

*'...I can say with confidence that, due to continuous audit and patient surveys, I am well aware of my outcomes compared with the gynaecological oncology community worldwide.'*

The benefits of clinical audit have been demonstrated many times in various specialties, but most work to date has been done in colorectal and vascular surgery. For example, a surgical audit on 600 colorectal patients from Victoria treated by 13 colorectal surgeons revealed that, overall, the leak rate, the percentage of patients requiring to be taken back to the operating theatre and the mortality was significantly reduced after clinical audit. Another study investigated mortality resulting from aortic aneurism surgery. Mortality was 9.6 per cent in patients treated in 1999 and 2000, but significantly reduced (8.3 per cent) in patients who had their surgery in 2001 after feedback about surgery outcomes was given to the participating surgeons. I am not aware of any data on outcomes of a clinical audit in gynaecology surgery for benign diseases.

## We know of four different ways of audit

### Standards-based audit

Unselected data is collected over a certain time (for example, six months) to measure current practice against defined standards; for example, what is the percentage of my patients being converted from laparoscopy to open surgery for hysterectomy? Ideally, a gynaecologist would then be able to compare her/his data with data from colleagues in an anonymous way. CUSUM (cumulative sum control chart) analysis refers to the possibility of plotting unwanted outcomes (for example conversion) against time to see if performance improved.

### Critical incident monitoring

Incidents will trigger a review process – a multidisciplinary team discusses individual cases to reflect upon the way the surgical team functioned. Incidents are pre-defined (for example, intraoperative viscous injury, take back to the operating theatre, unplanned admission to ICU, etc). Nowadays, most public and private hospitals require clinicians to participate in morbidity and mortality (M&M) meetings. In our unit, information shared amongst the participants of the M&M meeting is privileged (must not be disclosed to third parties).

### Peer review

Individual, selected cases are discussed in confidence between colleagues if the clinician is uncertain whether best care was given (benefit of hindsight).

### Patient surveys

Patient surveys are used to obtain consumers' views about the quality of care they have received.

## How can gynaecologists interested in auditing their performance get started?

1. A gynaecologist can start a standards-based audit straight away by entering her/his surgical and/or obstetrics cases into a database. Data to be entered will need to include a patient's identification code, treatment and outcomes as well as confounding variables (factors that may influence outcomes, for example, body mass index, existing co-morbidities, etc). Newer versions of databases are web-based, provide total anonymity, are secure (SSL certificate, password protected) and allow for benchmarking against peers and national averages. One such web-based database with fully automatic comparison algorithms has become available for general gynaecology and obstetrics recently ([surgicalperformance.com](http://surgicalperformance.com)).
2. Every gynaecologist performing surgery should participate in a morbidity and mortality meeting. Index cases (cases with an unwanted outcome) and patterns of failure are discussed. This design should allow for the opportunity to improve knowledge, to identify surgical errors or to identify inadequate systems and processes within the healthcare facility that need to be improved to optimise outcomes. For example, it may be identified that a recently increased rate of intraoperative nerve injury is attributable to 'wear and tear' of old surgical retractors. Replacement of this old equipment should result in a return to an adequate nerve injury rate.

3. Ask a colleague of your choice to discuss a couple of cases in confidence. Sometimes it is also helpful to join someone in the operating theatre to see how other people approach different situations. For example, I went to study some surgical procedures at the Memorial Sloan-Kettering Cancer Center, New York, in July last year and the experience (What do they do better? What do we do better? Where do these surgeons have a different approach and why?) has been fantastic.
4. Surveys can be sent after surgery to find out about patients' "hospital and doctors' experience". For the last three years, I survey all my patients at six weeks after surgery. Patients are quite willing to share their experiences and I have been able to use this information to improve systems and processes in the running of my practice, to make them most convenient to my patients and to achieve the highest possible patient satisfaction ratings.

A number of other audit pathways exist for gynaecologists. My personal experience with audit has been exciting and improvements based on the audit have involved additional work and training, but have always been extremely worthwhile. I don't think I'd practise gynaecological oncology again without the experience of continuing audit.

Professor Andreas Obermair is a gynaecological oncologist in Brisbane and developed the SurgicalPerformance.com project for the self-audit of O and G specialists.

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**Have you attended a conference and don't know how many CPD points to claim?**

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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.

## Birth outcomes after induced termination

This Canadian systematic review analysed 37 studies of birth outcomes after induced termination. They report that a history of one induced termination resulted in an increased risk of low birthweight (unadjusted OR=1.35 95% CI 1.20-1.52) and preterm birth (OR=1.36, 1.24-1.50). A history of more than one termination was associated with a further increased risk (LBW OR=1.72, 1.45-2.04); preterm birth (OR=1.93, 1.38-2.71). Proposed mechanisms for the association between termination and adverse pregnancy outcome include overt or covert infection following termination, mechanical trauma to the cervix, and endometrial scarring leading to abnormal placentation and placenta praevia. It is also possible that there is some common factor associating women likely to have a termination with a higher risk of adverse pregnancy outcome. *BJOG* also provides a free podcast in which four academics discuss the findings of the paper. In addition to discussion of the paper at hand, the discussants raise questions of increasing rates of preterm birth associated with an increase in the rate of termination, particularly in the United States. Gynaecologists listening to the podcast may be struck by the apparent impact of studies such as these on people with previous concerns regarding termination and for the potential widespread impact of these findings on public policy. Similarly, it is instructive to hear three readers come to very different conclusions when presented with the same article.

Shah P, Zao J on behalf of Knowledge Synthesis Group of Determinants of Preterm/LBW Births. Induced termination of pregnancy and low birthweight and preterm birth: a systematic review and meta-analyses. *BJOG* 2009; 116: 1425-1442.

Podcast at: [www.bjog.org/view/0/podcasts.html](http://www.bjog.org/view/0/podcasts.html)

## Surgical approach to hysterectomy for benign gynaecological indications

This is the most recent of a series of Cochrane reviews by this group of authors analysing studies comparing abdominal, vaginal and laparoscopic hysterectomy for benign gynaecological indications. 34 studies involving over 4000 women were included in the analysis. Compared to abdominal hysterectomy, vaginal hysterectomy had a shorter hospital stay, faster return to normal activities and fewer infections. Laparoscopic hysterectomy had a shorter hospital stay, lower blood loss, faster return to normal activities and fewer wound infections than abdominal hysterectomy, but a higher rate of urinary tract injuries and a longer operating time. Readers may note that the effect for more urinary tract injuries in laparoscopic hysterectomy is influenced substantially by Garry's 2004 eVALUate study. There were no benefits for laparoscopic compared to vaginal hysterectomy and the laparoscopic approach had a longer operating time. The authors concluded that they would recommend vaginal as the preferred approach to hysterectomy for benign gynaecological conditions. If a vaginal approach is not possible, then individual surgeons and their patients should make a decision as to whether to pursue an abdominal or laparoscopic approach.

Nieboer TE, Johnson N, Lethaby A, Tavender E, Curr E, Garry R, van Voorst S, Mol BW, Kluivers KB. Surgical approach to hysterectomy for benign gynaecological disease. *Cochrane Database Syst Rev.* Jul 8 2009; (3): CD003677.

## Progesterone to prevent preterm birth in twin pregnancy

The use of progesterone to prevent preterm delivery is currently of great interest in obstetrics with a number of large trials underway. The authors of this article focused on twin pregnancies, which have a greater risk of preterm delivery than singleton pregnancies. A double-blind placebo-controlled trial randomised 500 women with twin pregnancies to receive either 90mg vaginal progesterone gel or placebo gel for ten weeks from two weeks gestation. The results showed no significant difference in intrauterine death or preterm delivery between the progesterone and placebo groups. The authors also performed a meta-analysis of three previous randomised studies attempting to use progesterone to prevent preterm birth in twins. Again, they concluded that progesterone had no significant effect on preventing preterm birth in twin pregnancies.

Norman JE, Mackenzie F, Owen P, Mactier H, Hanretty K, Cooper S, Calder A, Mires G, Danielian P, Sturgiss S, MacLennan G, Tydeman G, Thornton S, Martin B, Thornton JG, Neilson JP, Norrie J. Progesterone for the prevention of preterm birth in twin pregnancy (STOPPIT): a randomised, double-blind, placebo-controlled study and meta-analysis. *Lancet* 2009; 373: 2034-40.

## RANZCOG Application Aide - TGA Prescriber Status for Mifepristone and Misoprostol

For those seeking to become an authorised prescriber for Mifepristone and Misoprostol, contact RANZCOG for a free application aide:

Nola Jackson  
Women's Health Officer  
(t) +61 3 8415 0408  
(e) [njackson@ranzco.edu.au](mailto:njackson@ranzco.edu.au)

# H1N1 09 influenza and pregnancy

**Dr Justin Denholm**

FRACP

Victorian Infectious Diseases Service  
Royal Melbourne Hospital

**While influenza A has long been associated with infection in pregnancy, the recent pandemic (H1N1 09) influenza has been marked by greater than anticipated reports of severe illness in pregnant and postpartum women. Several early deaths of previously healthy women in the United States contributed to concerns about H1N1 09 influenza in pregnancy.**

However, later in the pandemic period came claims that infection with the H1N1 09 strain was less serious than initially thought, leaving many confused as to the true importance of infection.

Where do we stand now with understanding the impact of H1N1 09 in pregnancy? Looking back at the end of the first pandemic season, a number of studies have now helped to establish that H1N1 09 can cause significant morbidity and mortality in pregnancy, although perhaps not to the extent first feared. Our own study of the first two months of the Australian pandemic experience found there was a striking over-representation of pregnant women, with 25 per cent (15/60) of women hospitalised in Melbourne being pregnant or immediately postpartum. This group of patients also experienced significant morbidity with a mean length of stay of 6.5 days; longer than the overall mean of four days in non-pregnant patients. Finally, one third of pregnant patients admitted required intensive care management during their stay. Certainly, it is clear that some pregnant patients with H1N1 09 infection experience significant illness, although it remains uncertain what proportion of those infected this represents. In addition to these significant maternal infection risks, influenza infection in pregnancy has also been associated with miscarriage and premature labour, with consequent negative impact on the fetus and neonate.

*'For the upcoming season, the World Health Organisation has indicated that the 2010 trivalent influenza vaccination will include the H1N1 09 pandemic flu strain. Until this time, it is recommended that pregnant women continue to receive the monovalent vaccine; however, once the trivalent is available this will no longer be necessary.'*

It is not completely clear why pregnancy, particularly late pregnancy, appears to increase the risk associated with influenza infection. Changes to pulmonary ventilation and blood flow have been proposed, as have alteration in various aspects of cellular and humoral immunity. Most likely, a range of factors contribute to this susceptibility, although it remains to be seen how the influenza virus differs from other pathogens in effectively exploiting these changes.

Although the 2009 pandemic period has ended in Australasia and the 2010 peak has not yet begun, there continues to be low-level

community transmission of H1N1 09 influenza, with small numbers of cases each week. Pregnant women who become infected with influenza should be treated with an appropriate antiviral agent as early as possible, preferably within 48 hours of symptom onset. Oseltamivir (Tamiflu, Roche) has been widely used in pregnancy and remains first-line therapy, although clinicians should be aware that drug-resistance has been reported in small numbers of Australian patients. Zanamavir (Relenza, GlaxoSmithKline) is an alternative for women who do not have pre-existing lung disease. Use of either agent is considered safe in breastfeeding. Chemoprophylaxis should also be considered for pregnant or postpartum women who have close contact (therefore household) with confirmed H1N1 09 infections.

Due to ongoing infections and the upcoming influenza season, vaccination continues to be recommended for pregnant women. Over the last few months, patients have had access to monovalent H1N1 09 (Panvax, CSL Biotherapies) vaccination. For the upcoming season, the World Health Organisation has indicated that the 2010 trivalent influenza vaccination will include the H1N1 09 pandemic flu strain. Until this time, it is recommended that pregnant women continue to receive the monovalent vaccine; however, once the trivalent is available this will no longer be necessary. The vaccine is considered to be safe throughout pregnancy and during breastfeeding, and can be administered in the same method normally followed for seasonal influenza vaccine. As with all influenza vaccines, immunity against infection is not absolute and women who develop H1N1 09 infection despite vaccination should be treated in the usual fashion.

Overall, caution is still required in the management of H1N1 09 influenza in pregnant and postpartum patients. Appropriate use of vaccination and antiviral medication can help to minimise the risk to mother and baby, and should be carefully considered for all patients in the lead-up to the 2010 influenza season.

## References

1. Denholm JT, Gordon CL, Johnson PD, *et al.* Hospitalised adult patients with pandemic (H1N1) 2009 influenza in Melbourne, Australia. *Med J Aust.* 2010; 192(2):84-6.
2. Jamieson DJ, Theiler RN, Rasmussen SA. Emerging infections and pregnancy. *Emerg Infect Dis.* 2006; 12(11):1638-1643.
3. Bozzo P, Djokanovic N, Koren G. H1N1 influenza in pregnancy: risks, vaccines and antivirals. *J Obstetric Gynaecol Can.* 2009; 31(12):1172-1175.



# Assisted reproductive treatment in Victoria

## *Obligations and opportunities*

### Narelle Everard

Legal Intern

Victorian Assisted Reproductive Treatment Authority

**New legislation often creates questions, some confusion and a need for education. The *Assisted Reproductive Treatment Act 2008 (Vic)*, which came into force on 1 January 2010, is no exception. So how will the new Act affect doctors, patients, donors and donor-conceived people?**

This article sets out some of the important aspects of the new legislative framework, focusing on changes that will impact upon clinical practice or the provision of patient education and advice.

#### General

The Act establishes the Victorian Assisted Reproductive Treatment Authority (which replaces the Infertility Treatment Authority). The Victorian Assisted Reproductive Treatment Authority has a number of key responsibilities, including registration and monitoring functions, public education and the promotion of research.

The Act also establishes the Patient Review Panel, which is responsible for reviewing applications relating to access to assisted reproductive treatment (ART) services in Victoria.

The Central and Voluntary Registers, now maintained by the Victorian Registry of Births, Deaths and Marriages, contain information about children born through donor treatment, their parents and donors. Information about applications to the Registers may be obtained from the Registry of Births, Deaths and Marriages on 1300 369 367 or [www.bdm.vic.gov.au/donorregister](http://www.bdm.vic.gov.au/donorregister).

*'...artificial insemination may only be performed by doctors... registered ART providers who were previously able to utilise nursing staff to perform artificial inseminations under the supervision of a doctor, are no longer able to do so.'*

#### Clinical practice

A significant change has been made relating to artificial insemination procedures. With the exception of self-insemination, which is expressly unregulated, artificial insemination may only be performed by doctors. This means that registered ART providers who were previously able to utilise nursing staff to perform artificial inseminations under the supervision of a doctor, are no longer able to do so. The penalty for failing to comply with this requirement may

be four years imprisonment and a fine in excess of A\$56,000 or both.

Doctors who wish to undertake artificial insemination as part of their private practice do not need to be affiliated with a registered ART provider. However, they should be aware that there are comprehensive consent, counselling, record-keeping and reporting requirements. Doctors who wish to extend their repertoire of services into artificial insemination are advised to refer to the new Act to ensure that all practices and procedures comply with the requirements of the Act. The Victorian Assisted Reproductive Treatment Authority is able to provide information regarding legislative compliance. The website ([www.varta.org.au](http://www.varta.org.au)) is a valuable source of information for interested practitioners.

#### Mandatory counselling

Prior to treatment, it is necessary for a woman (and her partner if she has one) to receive counselling from a counsellor who provides services on behalf of a registered ART provider. This also applies to doctors undertaking artificial insemination.

#### Eligibility for treatment

ART procedures are available to all people, regardless of gender, sexuality or relationship status, unless the mandatory criminal records check or child protection order check contraindicates treatment. This is known as a presumption against treatment and is explained in more detail below. A treatment procedure may be performed on any woman who is unlikely to become pregnant given her particular circumstances. ART is also available to women who are not able to carry a child or give birth without such a procedure, or where genetic factors indicate that such a procedure is necessary to prevent transmission of a genetic abnormality or genetic disease.

#### Presumption against treatment

Under the Act, ART may not be performed unless a criminal records check and a child protection order check have been undertaken by the prospective patient and their partner, if they have one.

A presumption against treatment will apply where a person has been charged with a specified sexual offence and this charge has been proven against them, or where a person has been convicted of any violent offence of a specified type, or where a child protection order has been made removing a child from the custody of a person. In these circumstances, registered ART providers and doctors are prohibited from providing ART services.

Where a person wishes to have this presumption against treatment overturned, they may apply to the Patient Review Panel for a review of their case. The Victorian Civil and Administrative Tribunal (VCAT) is the body legislated to review decisions made by the Patient Review Panel where required.

### Donor issues

If a person is seeking information on becoming a donor in Victoria, there are a number of issues to consider, including the requirement that donors must provide information to a Central Register. This information is stored with the Registry of Births, Deaths and Marriages, so that people involved in donor conception can access details about their biological origins if they wish.

Donors must also be told that a Voluntary Register exists and that its purpose is to facilitate a voluntary exchange of information between specific persons involved in donor treatment, including people born as a result of donor treatment, donors and the relatives of those directly involved.

Donors must consent to the use of their gametes for a specific kind of procedure and must specify the number of women on whom their gametes may be used. A maximum of ten families may be created using an individual donor's gametes. This includes any families the donor may have created with their current or any former partner with or without the assistance of ART.

Consent for the use of donor gametes is valid for ten years unless a shorter period has been specified or unless the donor has withdrawn their consent. However, consent may only be withdrawn up until the time that an embryo is formed and must be done in writing in accordance with the Act.

*'...ART may not be performed unless a criminal records check and a child protection order check have been undertaken by the prospective patient and their partner, if they have one.'*

### Surrogacy arrangements

Surrogacy is available to individuals and couples regardless of the commissioning person's gender or sexual preference. Commissioning individuals must be unlikely to become pregnant, carry a pregnancy or give birth. Alternatively, pregnancy or birth must pose a risk to the life or health of a commissioning woman.

The woman acting as a surrogate must be at least 25 years old and have already given birth to a live child. A surrogate must not use her own oocyte for the procedure.

All surrogacy arrangements require approval from the Patient Review Panel. Prior to seeking such approval, all parties involved, including any partner of a surrogate, must receive counselling from a counsellor who provides services on behalf of a registered ART provider and obtain independent legal advice.

Surrogacy arrangements must be altruistic. There must be no commercial component to the arrangement and the surrogate must not be financially or otherwise materially advantaged by the arrangement. However, there is provision for legitimate reimbursement of out of pocket expenses.

While the surrogate woman will be presumed to be the mother of the child at birth, the commissioning parents will be able to apply to the Courts for a parentage order to have the birth certificate altered to reflect the social familial relationships, as long as the consent of the surrogate mother is obtained. Applications made when a child is between 28 days and six months old will be processed routinely. Applications made outside of this timeframe will require the leave of the Court before they will be considered.

### Posthumous use of gametes

Gametes or embryos from a deceased person may only be used where the deceased person has provided express consent, in writing, authorising such posthumous use. If consent was provided, the gametes or embryos may only be used to assist the deceased person's partner to conceive, unless the deceased person is a woman, in which case the woman's male partner is able to commission a surrogacy arrangement.

All posthumous use must be approved by the Patient Review Panel prior to treatment.

Given the requirement for written consent, it may be important to raise the issue of posthumous use with people having treatment for life threatening conditions, or where gametes or embryos are being stored for future use. Such forward planning will help to facilitate the fulfilment of their wishes in the event of their death.

### Donor-conceived people

Under the new Act, donor-conceived people are presumed to have a right to know about their genetic background. Provisions in the Act set out the requirements for the collection, storage and dissemination of information to and from relevant parties. While Victoria has mandated the gathering and storage of information relating to donor conception for some time, this Act goes further than previous legislation in facilitating access to information about genetic background.

Recipient parents are told about the Central Register in pre-treatment counselling and are encouraged to tell their child about the method of their conception. Donor-conceived people born under the new Act will, upon reaching 18 years of age, be advised of the availability of additional information relating to their birth when they apply for a birth certificate. This change makes it increasingly likely that people may seek advice about how to tell family members about donor involvement in their child's conception, or about their role as a donor in someone else's life.

Resources to help with the 'telling' process are available through the Victorian Assisted Reproductive Treatment Authority. These resources feature various family arrangements and include age appropriate advice and tools, story book texts, flyers, web-based articles and a number of podcasts. For more information or to access these resources, contact the Victorian Assisted Reproductive Treatment Authority.

### Conclusion

This article has provided a brief synopsis of some of the issues that may be pertinent for obstetricians and gynaecologists in clinical practice. It is intended to draw attention to the new legislative regime and is not intended to provide a definitive or comprehensive legal opinion, or in any way be a substitute for independent legal advice.

**For further information about the provision of ART services in Victoria, contact the Victorian Assisted Reproductive Treatment Authority on +61 3 8601 5250 or visit the website at [www.varta.org.au](http://www.varta.org.au) .**

# The National Register of Antipsychotic Medication in Pregnancy (NRAMP)

## Heather Gilbert

RN Division 1/Research Nurse  
Monash Alfred Psychiatry Research Centre  
Alfred Hospital, Melbourne

### Vignette overview

Kathy, a 35-year-old woman with a long history of bipolar affective disorder, works fulltime as a healthcare professional. Her mental illness has been treated effectively with quetiapine 400mg/day, a second generation antipsychotic (SGA). Kathy and her husband want to start a family.

### Introduction to NRAMP

The opportunity and means with which to maintain optimum health and wellbeing throughout pregnancy are both desired and expected in our 'civilised' communities, as are optimal outcomes at the time of delivery for both mother and baby. This coincides with the expectation that all women will maintain the ability to take care of their baby, no matter what their situation, including women who experience mental illness and who are prescribed antipsychotic medication during pregnancy. Subsequently, responsibility falls heavily upon healthcare professionals, as they strive to provide appropriate and timely perinatal care to women in this vulnerable population group.

Unfortunately, there is little or no information available to clinicians regarding the impact of SGAs on the developing fetus, however, it is clear that SGAs produce fewer side effects, are well-tolerated by the patient and more effectively target the symptoms of psychosis, while providing effective treatment for bipolar affective disorder, schizophrenia and related illnesses.

Most women with a serious psychiatric illness cannot stop taking their medication during pregnancy, as this may lead to a relapse of illness or interfere with their capacity to manage their activities of daily living, especially taking care of an infant. It is therefore important to evaluate the safety of these medications in pregnancy. In the absence of clinical trials, which are the gold standard for medication safety research, but are unlikely given ethical considerations, we must rely on observational studies. Data collected by this method can be a useful source of evidence-based information, providing strategies for achieving a balance between maternal mental health and minimal risk to the fetus.

### Vignette conclusion

Kathy consented to participate in NRAMP, which allowed us the opportunity to follow her progress along with that of her baby, during pregnancy, delivery and for 12 months postnatally. At 24 weeks gestation, Kathy's mental health deteriorated, resulting in a hospital admission of four weeks for acute psychosis; quetiapine was increased to 1200mg/day. Kathy was subsequently discharged

home at 28 weeks gestation, following a marked improvement in her mental health. Kathy delivered a healthy baby girl, weighing 3235g, by caesarian section, at 38 weeks gestation. At the six-month follow-up, mother and baby were progressing well.

### National Register of Antipsychotic Medication in Pregnancy

NRAMP is an observational, nationwide study which will culminate in an important best-practice resource to improve the quality of life for both present and future generations. We highly value the encouragement and support of all clinicians, and strongly urge you to refer appropriate patients to this ground-breaking and innovative research.

### Study aims

- To provide a better understanding of antipsychotic medication use during pregnancy, birth and for the first year of the baby's life.
- To thereby allow for improved treatment options and encourage safer outcomes for both mother and baby.

### NRAMP seeks women who:

- Are taking/have taken antipsychotic medication during pregnancy
- Are currently pregnant or have had a baby in the last 12 months
- May have an Axis I, DSM-IV diagnosis
- Live in Australia
- Are able to provide informed consent.

### Further reading

1. Gilbert H. 'About Helen' – antipsychotic medication use during pregnancy. A Case Study. *The Australian Nursing Journal*, February 2009, Vol16, No7, p20.
2. Kulkarni J, McCauley-Elsom K, Marston N, Gilbert H, Gurvich C, de Castella A, Fitzgerald P. Preliminary findings from The National Register of Antipsychotic Medication in Pregnancy. *The Australian and New Zealand Journal of Psychiatry* 2008, 42:38-44.

**We welcome your queries, comments and referrals.**

**Chief Investigator: Professor Jayashri Kulkarni**  
**Research Nurse/Study Coordinator: Ms Heather Gilbert**

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## REQUESTS FOR EXTENSION TO CONTINUING PROFESSIONAL DEVELOPMENT (CPD) PERIOD

### Extension requests – six months and greater

Have you been absent from medical practice for a period greater than six months due to maternity leave, ill health or other exceptional circumstances?

If so, why not apply for an extension to your current Continuing Professional Development (CPD) period?

### APPLICATION

Requests for extensions can be made in writing to the Chairman of the Continuing Professional Development Committee (CPDC). Proof of maternity leave, ill health or exceptional circumstances must be supplied.

### PROCESS

The Chairman of the CPDC will consider requests for extension of six to 12 months. Requests greater than 12 months will be considered by the full CPDC, which meets three times a year (March, July and November).

If you are absent from practice for a period greater than two years, please see the re-entry policy following a prolonged absence from practice at: [www.ranzcog.edu.au/publications/statements/wpi13.pdf](http://www.ranzcog.edu.au/publications/statements/wpi13.pdf).

For further queries contact:

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## The Royal Australian and New Zealand College of Obstetricians and Gynaecologists

### ***WANTED: VOLUNTEER FACILITATORS FOR RANZCOG BASIC SURGICAL SKILLS WORKSHOPS***

Fellows and Year 5 and 6 Trainees are needed to act as facilitators at the RANZCOG Basic Surgical Skills (BSS) workshops conducted annually in each State in Australia and in New Zealand. Attendance at a BSS workshop is compulsory for all Year 1 RANZCOG Trainees.

These practical, interactive two-day workshops are run on weekends and cover theatre etiquette, handling instruments, knot tying, incision/closure, episiotomy repair, haemostasis, electrocautery and stacks, hysteroscopy and laparoscopy.

Facilitators provide hands-on teaching and advice during the workshop and help with setting up on the day. Time commitment: ONE weekend per year.

*Applications and enquiries: Shaun McCarthy, Training Services Manager  
tel +61 3 9412 2917, fax +61 3 9419 7817, email: [smccarthy@ranzcog.edu.au](mailto:smccarthy@ranzcog.edu.au)*



# Core Competencies and Educational Framework for Maternity Services in Australia Project

## Marnie Griffiths

Project Officer  
Centre for Midwifery, Child and  
Family Health  
University of Technology Sydney

**The Core Competencies and Educational Framework for Maternity Services in Australia Project is well underway. It is co-sponsored by the Maternity Services Inter-Jurisdictional Committee (MSIJC) and the National Health Workforce Taskforce (NHWT).**

This innovative project aims to determine core competencies and an educational framework to act as a benchmark to inform curricula development for primary maternity service providers in Australia. The project also highlights the importance of an interprofessional approach to primary maternity services to ensure they can achieve the best outcomes for women, their babies and families.

This project is divided into two parts:

**Part One:** The identification and development of a Primary Maternity Service Competency Model.

**Part Two:** The development of an Educational Framework for Primary Maternity Services in Australia.

Part One of the project is now complete. The focus of Part One was the development of core competencies for primary maternity services for the care of pregnant, birthing and postpartum women of normal risk. The core competencies have been developed collaboratively and focus on the needs and preferences of women, the promotion of greater access to continuity of care and the fostering of effective interpersonal relationships between providers of care.

The Core Competencies for Primary Maternity Services Model document is available online at: [www.nmh.uts.edu.au/cmcfh/whatwedo/maternity-services.html](http://www.nmh.uts.edu.au/cmcfh/whatwedo/maternity-services.html). This document provides important background information regarding the development of

the core competencies for primary maternity services in Australia. It also provides details of the developed competencies and the consultation process undertaken to develop them. As the project is not yet complete, minor changes may still be applied to this document. The final model will be released in June 2010 at the projects' completion.

Part Two of the project is now in progress. The Core Competencies Model has been used to inform Part Two. The identified competencies have provided guidance to the development of an educational framework and a set of general educational principles for primary maternity services in Australia. A draft of the educational framework is ready for wider web-based consultation. The project team is currently seeking comment and feedback from all healthcare professionals who are involved in maternity care as well as from consumers. The project team welcomes your feedback and comments. This document is also available at: [www.nmh.uts.edu.au/cmcfh/whatwedo/maternity-services.html](http://www.nmh.uts.edu.au/cmcfh/whatwedo/maternity-services.html). The webpage has a link to the survey and details on how to provide feedback. Feedback must be received by 12 March 2010.

**Should you have any questions related to this project contact:**

**The Project Officer**  
**Marnie Griffiths**  
**(e) [Marnie.Griffiths@uts.edu.au](mailto:Marnie.Griffiths@uts.edu.au)**

## Do you have a RACOG Fellow's gown that you no longer need?

If so, the Image and Regalia Working Party would like to hear from you as they are keen to obtain RACOG Fellow's gowns that are no longer used by their owners. The aim is to build up the existing collection of gowns at the College. We plan to have the gowns available for the use of members of Council, new Fellows being presented with their Fellowship and for hire by Fellows for special occasions (a fee is charged for the hire of the gowns to cover postage and handling).

- The gowns can be upgraded to a RANZCOG gown with the addition of silver braid.
- The collection of gowns is kept in a special storage area and maintained in excellent condition.
- The gowns are used by the Council members at every College function including Council meetings.

Any enquiries please contact:

Ros Winspear

Coordinator, Image & Regalia Working Party

ph: +61 3 9412 2934 fax: +61 3 9419 0672 email: [rwinspear@ranzocg.edu.au](mailto:rwinspear@ranzocg.edu.au)

# Module addressing the psychosexual care of women affected by gynaecological cancers

## Taryn Wishart

Project Manager  
Institute of Health and  
Biomedical Innovation  
**Queensland University  
of Technology**

Health and Biomedical Innovation (IHBI) to develop an interactive web-based training module and supporting resources for health professionals, to build their knowledge and skills in the psychosexual care of women affected by gynaecological cancers.

QUT is working in collaboration with gynaecological cancer nurses, psychologists, social workers and surgeons from the Sydney Cancer Centre and Westmead Hospital. In addition, insight and feedback is being gathered from a Project Working Group, comprising members from key professional bodies, multiple disciplines and backgrounds, including women affected by gynaecological cancers, and clinical and academic experts.

Once developed, the module and supporting material will provide training to professionals across all levels of healthcare, including general practitioners, nurses and oncologists. The module will focus on understanding sexuality, the woman's experience of the psychosexual effects of a gynaecological cancer, sexual function, assessment and advanced therapeutic interventions.

## Call for feedback on an interactive training module for health professionals to address the psychosexual care of women affected by gynaecological cancers.

The Australian Government, through Cancer Australia's National Centre for Gynaecological Cancers, has commissioned Queensland University of Technology's (QUT) Institute of

The module, which will be structured to enable a range of health professionals who care for women with gynaecological cancers to tailor the content to their needs, will be delivered in both electronic and hard copy format to promote flexibility and accessibility. In addition, supporting resources will include psychosexual assessment and referral tools, as well as information about psychosexual support and other resources that health professionals can offer to patients to support the counselling process.

The module will contain case studies which draw on the real-life experiences of women treated for gynaecological cancers, to allow personal insight into the issue and to ensure an engaging training experience for health professionals.

It is anticipated that the module will be available through the Cancer Learning website in the second half of 2010.

QUT is interested in receiving feedback on this important issue from consumers and health professionals from an array of disciplines throughout the development process.

**To learn more about this module and to be kept informed on the progress of this project, or to have your say on draft materials, please visit our website: [www.hlth.qut.edu.au/nrs/research/researchprojects/gyn/welcome.jsp](http://www.hlth.qut.edu.au/nrs/research/researchprojects/gyn/welcome.jsp) .**

## Are you registered on the RANZCOG website under our 'locate an obstetrician/gynaecologist' link?

Can your colleagues locate you for referral purposes?

On the College website, two 'Register of Fellows' are published: a publicly accessible register of active Fellows in Australia and New Zealand and a restricted access register of all College members.

The PUBLICLY ACCESSIBLE 'Register of Active Fellows' lists your work address, phone number and brief practice details (for example, private and/or public obstetrics and gynaecology or area of subspecialty).

The RESTRICTED ACCESS 'Membership Register' lists the work contact details of members of the College who wish to be included and is accessible only by members of the College who have a website user name and password.

If you would like your work contact details to be included on either or both of the registers and/or would like to update your details already listed on the website, please contact:

Tracey Wheeler  
(t) +61 3 9417 1699  
(e) [reception@ranzocg.edu.au](mailto:reception@ranzocg.edu.au)

# Updates from the Pacific Society for Reproductive Health

## Yvonne Kainuku-Walsh

PSRH Executive Officer

## Dr Alec Ekeroma

PSRH Honorary Treasurer

**Head, Pacific Women's Health Research and Development Unit**

What an exciting year it has been, with almost ten months under my belt as Executive Officer of the Pacific Society for Reproductive Health (PSRH). I can honestly say there aren't too many dull moments, with challenges and rewards in abundance. I joined the PSRH soon after the March 2009 Biennial General Meeting in Auckland, New Zealand, where a meeting chaired by Dr Peter White and Dr Roy Watson identified key strategic objectives for the organisation. One should expect to hold onto their hats as the train rolls swiftly along with the enthusiasm and high expectations of delivery.

The main objectives of the PSRH:

- Improve maternal health – reduce maternal mortality and morbidity
- Integrate HIV-STI into reproductive health programs
- Improve adolescent sexual and reproductive health
- Build capacity in reproductive health research
- Continue professional development and capacity of the workforce.

The PSRH 2009 biennial conference saw a record-breaking attendance. Delegates' feedback has delighted the organising committee with evaluations emphasising:

- Value of networking with colleagues from the Pacific, New Zealand and Australia
- Increase in knowledge
- Excellent hands-on practical workshops.

The workshops were so useful and relevant that participants from Fiji and the Cook Islands report they have used tools obtained at the emergency obstetrics skills workshop to launch similar workshops back home.

Over the past year, PSRH has had the pleasure of hosting four midwives at Middlemore Hospital in Auckland. Thanks to the continued support of the Brian Spurrett Foundation Fellowship, we had Relmah Harrington from the Solomon Islands and Asenati Tuilepa from Samoa visit Middlemore Hospital. Later in the year, the Fiji Government sponsored Makelesi Senikabuta and Malti Devi who joined us for six weeks.

The PSRH has also had the pleasure of welcoming new and well-established focal people from the 15 Pacific Island countries. Focal people act as a liaison for their countries, providing a flow of information from PSRH to their countries' maternal health sector and vice versa. Also, the PSRH has strong links with the Pacific Women's Health Research and Development Unit at the University of Auckland. In collaboration with PSRH, the unit is planning to build research capacity in the Pacific region.

On a larger scale, PSRH combined efforts with RANZCOG in a submission to the New Zealand Parliamentarians' Group on Population and Development (NZPPD) in response to an enquiry into how they may best address maternal health issues across the Pacific region. Following our joint submission, we were invited to deliver a 15-minute oral presentation to the NZPPD in Wellington in September 2009. PSRH assisted the NZPPD Secretariat in linking key Pacific personnel to inform the enquiry process. Along with Dr Alec Ekeroma and Dr Peter White, Sr Sulueti Duvaga (Fiji), Dr Gunzee Gawin (Papua New Guinea), Sr Kathleen Gapirongo (Solomons), and representatives from other Pacific Island countries, gave moving accounts of the extent of the need in the Pacific. About five maternal deaths tragically occur in the Pacific every day and most of these will be from preventable causes. PSRH and RANZCOG have the expertise, networking and infrastructural experience to deliver workforce-related programs. We are taking the opportunity to network with other non-government organisations working in the Pacific and regional funding agencies. The NZPPD report will be launched in early 2010. PSRH and RANZCOG are hoping that the report will direct more resources into effective programs that will save and increase capacity in the Pacific.

The *PSRH Newsletter* provides information on various activities and comes out twice a year. To save printing and postage costs, we prefer emailing the newsletter to our financial members. For more details on PSRH membership, please contact Yvonne Kainuku-Walsh at: [ykwalsh@middlemore.co.nz](mailto:ykwalsh@middlemore.co.nz).



L to R: Dr Alec Ekeroma, NZPPD Chair Dr Jackie Blue, Ms Yvonne Kainuku-Walsh and Dr Peter White.

# Practice Visits in Australia

**Holly Coppen**  
SSRS Coordinator

**In 2009, RANZCOG successfully applied for funding from the Support Scheme for Rural Specialists (SSRS) to undertake practice visits in rural Australia.**

This project, based on the very successful New Zealand model, was championed by Dr Philip Hall and supported by the Provincial Fellows Committee and the Continuing Professional Development Committee.

## Who participated?

Fellows from throughout rural Australia were invited to participate in the project with 12 Fellows from six sites volunteering to receive a practice visit. A total of 22 Fellows were involved in the project, either as visitors or by receiving a visit or both.

## What is involved?

Prior to the day of the visit, the visited Fellow was required to complete and return a number of pieces of documentation including:

- A practice profile questionnaire
- A memorandum of understanding
- A three-month surgical audit logbook
- Fifty patient satisfaction questionnaires
- A self-assessment survey
- The program for the day of the visit, including arrangement of interview times with colleagues and obtained patient consent for the theatre observation.

Those Fellows who participated as audit facilitators were invited to attend a full day training event at College House on Friday 31 July 2009. The training event was attended by 13 Fellows and aimed to equip visiting Fellows with the skills to undertake the visit.

We were very fortunate to have Dr Mark Insull and Dr John Tait from New Zealand as speakers at the training event, with their vast knowledge of the Practice Visits process through the New Zealand experience.

## What did participants think?

Associate Professor Glyn Teale attended the training event prior to acting as a visitor. He commented that: *'Having attended the excellent training event, I felt well-prepared for the task at hand, although the nerves did build as the day of reckoning approached. My personal experience as a visitor included reviewing two Fellows in a joint practice. The two days were fantastically well organised and highlighted many excellent attributes of both Fellows' practice. In the end, only very minor recommendations could be made for a practice that was otherwise impressively well-run and patient-centered.'*

Dr Pieter Mourik participated in the project by acting as an audit facilitator for two visits: *'Participating in a practice visit is rewarding for both the doctor and the reviewers because of the sharing of knowledge and skills. Reviewers are in the enviable position to take home ideas to improve their own practice and the doctor being visited gains collegial and confidential support from a peer, enabling him or her to improve the care they provide to their patients.'*

Dr Fatima Ashrafi felt that: *'In endeavouring to provide excellence and best care to patients, practice visits are a very good way to go. It provides an avenue for reviewing and improving a doctor's practice and is an important quality assurance tool moving to the future. I thoroughly enjoyed the practice visit and I had a fantastic experience.'*

Dr Keith Hollebone, who also acted as a visitor, summed up his experience in three points: *'One, you are improving practice; two, you are doing something for the College; and three, you have a great time!'*

Feedback from all visitors was of a similar nature and highlighted the exceptionally high level of patient care in the practices that were visited.

Despite the fact that this was a resource and time-intensive project, feedback from participants has been uniformly positive. Benefits to Fellows included:

- Reducing professional isolation
- Provided feedback on performance
- Highlighting areas of vulnerability in practice.

Visiting Fellows indicated that they also benefited from the experience and in many cases implemented changes in their practice.

## What next?

The SSRS program comes to a close in June 2010 to be replaced by the Commonwealth-funded Rural Health Continuing Education (RHCE) sub-program, a consolidation of rural continuing education and training support programs. The RHCE aims to encourage increased collaboration between stakeholder groups and foster multidisciplinary team-based training and joint continuing education.

The Provincial Fellows Committee has considered a number of CPD opportunities that may be developed into a RHCE funding application.

**SOLS facilitates Specialist and GP Obstetric locum placements in rural and remote Australia (RRMA 3 to 7 or ASGC-RA 2-5).**

## DID YOU KNOW?

**For each financial year, eligible Obstetricians are entitled to:**

- 14 days of subsidised locum support**
- Subsidised locum travel costs and travel time**
- Additional unsubsidised locum support**

Further information and application forms can be obtained from the SOLS website:  
[www.ranzcog.edu.au/sols/index.shtml](http://www.ranzcog.edu.au/sols/index.shtml)

Please direct all enquiries to the SOLS Secretariat:  
(03) 9412 2912 or [sols@ranzcog.edu.au](mailto:sols@ranzcog.edu.au)





# Perinatal Mortality and Morbidity Audit

**Holly Coppen**  
SSRS Coordinator

**Funding through the Support Scheme for Rural Specialists (SSRS) was again secured to run the Perinatal Mortality and Morbidity (PNM&M) Audit project during 2009. This project has been conducted over the past four SSRS funding rounds in all regions of Australia and once again it has been led by Professor Ian Pettigrew.**

The project aimed to improve the audit, investigation and peer review skills of regional and rural obstetricians and paediatricians who have been involved in perinatal adverse events, that have resulted in an unexpected transfer to a special care nursery, neonatal intensive care unit or a perinatal death.

## Who participated?

Professor Ian Pettigrew of Mildura, Victoria, has been the clinical champion of this project since its inception in 2004. Visits were undertaken at seven sites throughout rural Australia during the funding period, which concluded on the 31 December 2009. Direct involvement in the project involved 18 Fellows, one Area of Need practitioner and one perinatal epidemiologist (15 O and Gs and three paediatricians). However, approximately 58 other regional medical practitioners and allied health professionals were involved and interviewed in the audit process, including obstetricians, paediatricians, directors of medical services, medical superintendents, quality/risk managers, registrars, nurse unit managers, midwives, GP obstetricians and nursing directors.

## What was involved?

Each site retrieved medical records for adverse events that met the inclusion criteria over the last two years. The two audit facilitators then reviewed the records, provided feedback on clinical and systems issues and conducted interviews with various staff members involved in adverse events. The Fellow coordinating the visit at the site was provided with information flyers to distribute to colleagues so that they understood the collegiate nature of the audit project. At the end of the visit, the audit facilitators discussed the findings and made suggestions for improvement in collaboration with the clinicians involved.

A confidential report, identifying strengths and areas of vulnerability, was written and provided to the site coordinators following the visit. These reports, which are protected by Commonwealth Qualified Privilege, focused on clinical systems issues and offered recommendations that can be enacted by the department.

## What did participants think?

The PNM&M Audit project was very well received by participants, both facilitators and those at the sites. They indicated that they valued the collegiality of the project and the excellent continuing professional development (CPD) opportunity it provided for the multidisciplinary team.

Dr Pieter Mourik has been a participant in the project for a number of years and has provided some insight regarding his experience of involvement in the project (see box on right).

Benefits to Fellows included reducing professional isolation and provision of a forum where adverse events could be discussed openly.

## Dr Pieter Mourik Victoria

*Having had the privilege of conducting eight Perinatal Mortality and Morbidity Audits around Australia, I sincerely believe this worthwhile collegial support should be continued in the future if funding can be secured. Conducting these audits has been a most interesting and enjoyable experience.*

*Auditors gain an insight into how other maternity units work together as a team to provide an excellent standard of care to rural women, often under difficult or demanding circumstances. Since becoming an auditor, my admiration for the peers I have visited has increased. The standard of care for their patients has been exemplary and their dedication and competence is remarkable.*

*The widely known workforce shortage in obstetrics in rural Australia can be seen vividly during most audits, as most general practitioners have left obstetrics, leaving an ageing and overworked group of specialist obstetricians barely managing. One obstetrician had tears in his eyes when he thanked me and the College for taking an interest in him.*

*Many rural units are totally dependent upon overseas-trained specialists. In fact, in three units, there was not a single Australian-trained obstetrician.*

*The most tedious part of the review, albeit an essential part, is to review at least 20 hospital charts after babies died or were transferred to a special care nursery, or flown out to a tertiary unit. This is like showing your worst cases to the auditors.*

*Interviews were then conducted with key players, including the paediatricians, midwives and general practitioners, if any were involved. Postmortem results were studied and all pathology performed was compared to the Perinatal Society of Australia and New Zealand (PSANZ) guidelines. In most cases, it was encouraging to see appropriate investigations had been performed, protocols for investigating a stillbirth were followed and risk management was in place.*

*Counselling services were usually available for staff directly involved, although it was observed that, unfortunately, many obstetricians did not receive counselling themselves. In many cases the obstetricians were the counsellors.*

*Not strictly part of a perinatal audit, was observation of how different members of the maternity team worked together, either collaboratively or in conflict. Teams worked more collaboratively where educational opportunities for team growth occurred, for*

example, combined training in CTG interpretation; neonatal resuscitation; or fire drills of uncommon emergencies, such as eclampsia, postpartum haemorrhage and shoulder dystocia.

Participating in a perinatal audit is rewarding for both the doctor and the reviewers because of the sharing of knowledge and skills. Practising in a similar, isolated rural environment gives the auditors an understanding of the special problems involved in rural obstetrics.

This program is innovative and unique, because it is the only one that provides a quality control process to ensure correct procedures have been followed. At the same time, the program provides mentoring and counselling to rural obstetricians from a senior Fellow rural obstetrician who understands their working environment; an environment that is completely different from city practices.

I strongly believe that this program should be continued.

### What next?

The SSRS program comes to a close in June 2010, to be replaced by the Commonwealth-funded Rural Health Continuing Education (RHCE) sub-program, a consolidation of rural continuing education and training support programs. The RHCE aims to encourage increased collaboration between stakeholder groups and foster multidisciplinary team-based training and joint continuing education.

The Provincial Fellows Committee has considered a number of continuing professional development opportunities that may be developed into a RHCE funding application.

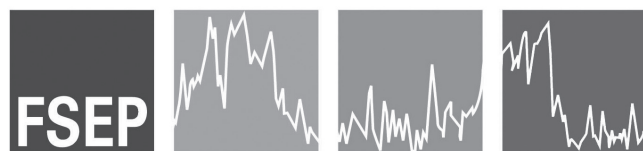
## Clinical Risk Management Activity Reflection Worksheet

**Have you attended a meeting or workshop that you wish to claim PR&CRM points for?**

If so this new worksheet is the one for you. It enables you to demonstrate that you have reflected on and reviewed in your practice as a result of attending a particular workshop or meeting. It also provides you with the opportunity to outline any follow-up work undertaken and to comment on plans to re-evaluate any changes made.

Download a form from the College website at:  
[www.ranzcog.edu.au/fellows/prcrmactivitieshtml](http://www.ranzcog.edu.au/fellows/prcrmactivitieshtml)  
**#RiskManagement**

For further information contact:  
**Jason Males**  
CPD & Curriculum Coordinator  
(t) +61 3 9412 2962  
(e) [jmales@ranzcog.edu.au](mailto:jmales@ranzcog.edu.au)



## FETAL SURVEILLANCE EDUCATION PROGRAM

**The RANZCOG Fetal Surveillance Education Program (FSEP) continues to deliver highly regarded fetal surveillance education to healthcare professionals in over 140 centres throughout Australia and New Zealand. As a RANZCOG program, the FSEP is not-for-profit and remains the leading cost-effective CTG education provider in Australasia.**

- Our clinical content is of the highest quality, comprehensively addressing fetal surveillance and CTG use. Our popular face-to-face programs facilitate adult learning whilst being time and resource efficient.
- We are continuing to develop our validated competency assessment tool and have released our online program (OFSEP) to support our face-to-face programs.
- We have published a fetal surveillance handbook to act as an additional resource, as well as meeting individual learning needs.
- Our workshops are accredited with the appropriate medical representative bodies and attract RANZCOG PR&CRM points. Additional PR&CRM points can also be earned by using our straightforward audit tool.

We are currently taking bookings for 2010.

For further information or if you are interested in booking or attending an education session, contact:

FSEP Administrator  
(t) + 61 3 9412 2958  
(e) [fsep@ranzcog.edu.au](mailto:fsep@ranzcog.edu.au)

## RANZCOG Application Aide - TGA Prescriber Status for Mifepristone and Misoprostol

For those seeking to become an authorised prescriber for Mifepristone and Misoprostol, contact RANZCOG for a free application aide:

Nola Jackson  
Women's Health Officer  
(t) +61 3 8415 0408  
(e) [njackson@ranzcog.edu.au](mailto:njackson@ranzcog.edu.au)

# DRANZCOG Objective Structured Clinical Exam

## September 2009

### A/Prof Ian Pettigrew

DRANZCOG OSCE Coordinator

The examination was held in the Dallas Brooks Centre, East Melbourne, and 68 candidates attended.

The examination consisted of 15 stations, all of which had two minutes reading time. The first station had eight minutes examination time and all the rest had seven minutes.

There were three procedural stations which included manikins:

1. The performance of a Pap smear. A standardised patient played the role of the woman having her first Pap smear.
2. An instrumental delivery which used a pelvis with a doll in a position suitable for an instrumental delivery; there was the option of using the Ventouse or forceps (critical station).
3. Neonatal resuscitation (critical station).

There were three telephone stations:

1. Management of a baby with neonatal jaundice.
2. Informing a woman who was diagnosed as a miscarriage that she probably had an ectopic pregnancy.
3. Management of a woman having an eclamptic fit (critical station).

The other stations focused on:

- Management of an abnormal Pap smear
- Counselling a teenager who had been sexually assaulted
- Counselling a woman about menopause
- Management of a postpartum haemorrhage (critical station)
- Pelvic pain
- Pre-pregnancy counselling of a 40-year-old woman
- Management of a woman with an unexplained stillbirth
- A 17-year-old with primary amenorrhoea
- A baby with failure to thrive as a result of a cardiac abnormality.

#### Station 1

The first station involved the explanation of and discussion about the management of a low-grade smear result following National Health and Medical Research Council (NH&MRC) guidelines. Candidates were also expected to explain how the woman contracted the human papillomavirus (HPV).

#### Station 2

The second station involved a neonate, discharged early from hospital, that failed to thrive. Candidates were expected to take a history regarding the birth, feeding and any other symptoms. Candidates were then given the result of the physical examination that showed the baby had a pan-systolic murmur. They then had to explain the diagnosis and refer appropriately.

#### Station 3

The third station related to a teenager who had not started having periods although the history included cyclical pain. Candidates were required to assess the hormonal status of the adolescent and arrange the appropriate investigations. The patient had not been sexually active and declined any examination. The ultrasound suggested a haematocolpos.

#### Station 4

The fourth station was about pre-pregnancy counselling in a woman aged in her 40s with a partner that had a family history of cystic fibrosis. Candidates were expected to mention the risks of miscarriage, malformations, medical complications and problems with delivery. Screening was also needed.

#### Station 5

This station involved a woman enquiring about hormone replacement therapy (HRT). Candidates were expected to take a full history, including risk factors and family history, and then advise in regard to HRT.

#### Station 6

This station explored some of the problems associated with sexual abuse in a minor and the need to involve the police and mandatory reporting. Candidates needed to outline to the standardised patient how they would manage the different problems such as possible pregnancy, sexually transmitted infections, contraception and follow-up.

#### Station 7

This was a straight-forward station regarding the management of a neonate with jaundice. Candidates needed to determine the clinical status, outline the appropriate investigations and outline the appropriate management, including phototherapy fluid balance and repeat serum bilirubin concentration (SBR).

#### Station 8

This was a phone station about a woman having an unexpected eclamptic fit. Candidates were expected to mention the ABC of resuscitation (airway, breathing, circulation), place the woman in a safe position, then outline the management including MgSO<sub>4</sub> and hypotansives.

#### Station 9

This station involved the interpretation of a histology report in an incomplete miscarriage that showed no chorionic villi, but an Arias-Stella reaction suggestive of an ectopic pregnancy. The station included informing the patient of the need to come into hospital because of her symptoms of abdominal pain.

#### Station 10

This was a critical station that involved the candidate talking to a 'medical student' about the management of a primary postpartum haemorrhage going through the '4 Ts' (tone, tissue, trauma and thrombosis).

**Station 11**

This involved the performance of a Pap smear using a manikin, but with a standardised patient passing comments and asking questions.

**Station 12**

This station was about breaking the news of an unexpected fetal death in utero near term and about the subsequent management, including investigations and delivery.

**Station 13**

This station involved the differential diagnosis of pelvic pain and involved history-taking and outlining the differential diagnoses.

**Station 14**

Candidates had to demonstrate and explain to the examiner how they would approach a woman in need of an instrumental delivery and to effect the delivery. This critical station used a manikin.

**Station 15**

Candidates were expected to demonstrate their skills in resuscitating the baby born at the previous station (critical station).

Despite the fact that the critical stations are known and that there are examples on the RANZCOG website, candidates still fail the exam, despite their overall score, because they failed two or more critical stations. All of the candidates I spoke to after the exam stated that they believed the critical stations were fair and necessary, as the DRANZCOG enabled doctors to be involved in intrapartum care and so should be competent in managing the common critical complications associated with looking after pregnant women.

This is my last report on the DRANZCOG examination. Dr Jeff Taylor, a GP from Narracorte, South Australia, has agreed to become the coordinator of the DRANZCOG OSCE.

I would like to thank all the RANZCOG staff for their support and assistance in running the exam over the last nine years. I would also like to thank all of the examiners who have given up their time to ensure that the quality of care given to Australian women by GPs involved in women's health is of the highest standard.

## College Connexion

Is there an event you'd like to advertise?  
Want to know the latest College news  
or clinical information?

Check out *College Connexion*,  
RANZCOG's notice board.

Created for all Fellows, Members, Trainees and Diplomates  
of the College, *College Connexion* includes courses  
and professional development opportunities;  
training and assessment information;  
workforce updates; and developments  
in women's health.

[www.ranzcog.edu.au/connexion/index.shtml](http://www.ranzcog.edu.au/connexion/index.shtml)

## MRANZCOG Research Assessors and Mentors Required

**Do you have a strong research background?**

**Would you like to support the development of  
research skills amongst our ITP trainees?**

College House is looking for research assessors and mentors to provide appropriate feedback and guidance to trainees undertaking their research proposals and projects. The research project is a compulsory requirement within the ITP/Elective training program.

### What is required?

You would be required to read the trainee's research proposals and provide feedback relating to the stated aims, hypothesis, project background, literature review, method, study design, statistics collection and analysis. This feedback is completed on a prepared template. As the College will also be conducting random audits on completed projects, you may be asked to assess a completed project as well.

RANZCOG is also preparing a mentor list so that trainees can be referred to a suitable research mentor if required. This position does NOT mean you would be mentoring a trainee for the duration of their research. Rather, you would be asked to provide timely advice and/or support on a needs only basis. Effective mentoring is not location specific and can utilise a range of technologies such as online, email and telephone communication.

If you are interested in being an assessor or mentor please send an email detailing your research interests and expertise to:  
Frances Gilleard  
(e) [fgilleard@ranzcog.edu.au](mailto:fgilleard@ranzcog.edu.au)

If you have any questions please contact:  
Bronwyn Robinson  
(t) +61 3 9412 2979  
(e) [brobins@ranzcog.edu.au](mailto:brobins@ranzcog.edu.au)



# MRANZCOG

## Structured Oral Exam

### October 2009

#### Prof Ian Symonds

SOE Coordinator

The structured oral examination (SOE) consists of eight stations covering the range of clinical practice in obstetrics and gynaecology. Each question is scored out of 20 including five marks awarded for overall performance (global competency). The scoring scheme for the remaining 15 points is developed during a two-day workshop conducted prior to the examination. The pass mark for each station is determined at the end of the workshop using modification of the Angoff standard-setting process. The pass mark for the examination is calculated as the sum of the pass marks for all eight stations. There are no 'critical' stations or encounters so that it is possible to 'fail' one or more individual stations and still pass the examination by strong performance in other stations. The marking scheme is structured so that a minimal acceptable passing standard candidate should be able to score at or above the pass mark for each station.

#### Station 1

##### Request for elective caesarean section for non-medical reasons (standardised patient scenario)

A 30-year-old woman presents to the antenatal clinic at 30 weeks of an uncomplicated first pregnancy and hands over a birth plan requesting elective caesarean section and tubal ligation. The latter is a request of her elderly partner; the former is a reflection of an absolute terror of vaginal delivery following her own mother's traumatic birth experience. There are no apparent medical indications for either intervention. A sensitive approach to both requests is needed and clues to the benefit of psychiatric support should be responded to. Following a precipitate labour and vaginal breech delivery at 39 weeks, the patient is reviewed. Her baby is well but in the nursery. An upset patient needs to be responded to sensitively and clues for postnatal depression should be detected.

Competencies tested:

- Management of a birth plan request for elective caesarean section and tubal ligation.
- Recognition of a significant history of anorexia nervosa and psychiatric risk.
- Organisation of appropriate follow-up and supports.
- Sensitive explanation of a traumatic vaginal delivery.
- Appropriate questioning of a new mother at risk of postnatal depression and recognition of significant distress.

#### Station 2

##### Cord prolapse in a former intravenous drug user

A 21-year-old woman is seen in the booking clinic in her fifth pregnancy at 19 weeks gestation. There is a history of opiate dependency, intravenous drug use (IVDU), previous intrauterine growth restriction (IUGR), domestic violence and removal of

previous children. The patient has poor IV access. Appropriate planning is needed for antenatal care, including addiction service input and social work. Booking tests show that she is hepatitis B positive. She presents at 30 weeks with threatened preterm labour, with transverse lie and has a cord prolapse after spontaneous rupture of membranes (SROM). Candidates are expected to describe how they would manage this case.

Competencies tested:

- Initial assessment and management of substance dependency in pregnancy.
- An appropriate response to previous history of IUGR and poor IV access.
- Recognition and response to a history of domestic violence.
- Management of hepatitis B status in pregnancy.
- Management of preterm labour in women with transverse lie.
- Management of cord prolapse.

#### Station 3

##### Delivery suite management

The candidate plays the role of the consultant on-call for delivery suite and is provided with a summary of patients in the delivery suite at the time of handover at 0800 hours. Additional information on the competencies of the staff available and on the clinical status of each of the women in delivery suite needs to be elicited and on this basis the candidate has to outline an initial plan of management. As the 'shift' progresses, symptoms of scar dehiscence develop in a patient undergoing a vaginal birth after caesarean (VBAC) requiring urgent delivery and, while this is being done, a significant postpartum haemorrhage (PPH) and fetal bradycardia occur in two other rooms. A woman at 28 weeks in advanced labour with a breech presentation arrives. The candidate is expected to indicate how they would prioritise these emergencies and use the available staff most effectively.

Competencies tested:

- Delivery suite management.
- Ability to prioritise and allocate resources to management of concurrent problems.
- Management of obstetric emergencies – PPH, fetal bradycardia.
- Management of preterm breech delivery.
- Management of VBAC.

#### Station 4

##### Pregnancy in a renal transplant patient

A 23-year-old nulliparous woman attends for pre-pregnancy counselling. She has had type I diabetes mellitus since the age of eight. She had a renal transplant five years ago. Her medications include immune suppressants and insulin. She presents six months later with a natural conception at eight weeks gestation. At 24 weeks, a growth scan shows a 22-week sized fetus. At 28 weeks,

she presents in renal failure. The fetus is at 24-week size. She requires delivery and intensive management.

Competencies tested:

- Provide preconceptual counselling for renal transplant and insulin-dependent diabetes mellitus (IDDM).
- Describe a suitable management plan for a renal transplant patient in pregnancy.
- Assess and manage early onset IUGR.
- Management of renal failure in pregnancy.
- Management of a very preterm and small-for-dates delivery.

### Station 5 Molar pregnancy

A 29-year-old nulliparous woman has recently emigrated from overseas and presents with a large-for-dates early pregnancy. Clinical symptoms are minimal apart from excessive nausea. Subsequent investigation shows ultrasound features of a partial mole (abnormal placenta with a co-existent fetus) and fetal abnormality. An amniocentesis is requested and shows triploid. Termination of pregnancy is performed without complication. Appropriate follow-up then needs to be discussed with the patient.

Competencies tested:

- An awareness of the various causes of a large-for-dates early pregnancy.
- Recognition of the ultrasound features that make up a partial mole and an understanding of the underlying chromosomal abnormality (triploidy) with the extra set of chromosomes being maternal or paternal.
- An understanding that this is a non-viable pregnancy, which should be reasonably terminated.
- Recognition of the possible but low-risk of recurrence and ongoing trophoblastic disease.

### Station 6 Menorrhagia and chlamydia in a teenager

A 14-year-old is brought into the gynaecology clinic by her mother because of heavy periods. Appropriate assessment needs to be performed and management options discussed. At follow-up, she complains of vulval pruritus due to vulval warts. Sexually transmitted infections screening is positive for chlamydia. This requires treatment and appropriate response to child protection issues and counselling about contraception. She is subsequently admitted to emergency with acute onset lower abdominal pain and the candidates are expected to recognise and manage a ruptured ectopic pregnancy.

Competencies tested:

- Management of menorrhagia in adolescents.
- Prescribing contraception to under 16-year-olds.
- Recognition and management of ruptured ectopic pregnancy.
- Management of vulval warts and chlamydia.
- Recognition of issues of consent and confidentiality in patients below the age of consent.

### Station 7 Urinary tract injury at laparoscopically assisted vaginal hysterectomy

A 46-year-old woman is referred for the management of heavy periods. Cells suggestive of adenocarcinoma in situ (ACIS) are recognised on Pap smear. A colposcopy and cone biopsy is performed. ACIS is confirmed and a laparoscopically-assisted vaginal hysterectomy (LAVH) recommended. The patient needs to be counselled about what this involves and the potential risk.

On day seven, after the operation, the patient develops urinary incontinence and a vesico vaginal fistula needs to be diagnosed and management commenced.

Competencies tested:

- Initial assessment and management of menorrhagia.
- An appropriate response to atypical glandular cells on Pap smear.
- Explanation of a required cone biopsy.
- Management of ACIS with upper margins just clear.
- Counselling and explanation of risks prior to a proposed LAVH.
- Management of a possible bladder injury following LAVH.

### Station 8 Endometrial hyperplasia in a woman with previous history of thromboembolism

A 52-year-old woman with a BMI of 45, type 2 diabetes and long-term warfarin therapy for a past history of pulmonary embolism (PE) is referred to the gynae clinic with postmenopausal bleeding. Out-patient endometrial biopsy shows atypical hyperplasia. There is discussion about the next step and the perioperative management of her anticoagulation. She subsequently undergoes hysterectomy. Histology of the endometrium shows endometrial carcinoma involving more than 50 per cent of the thickness of the myometrium and she has treatment with radiotherapy. At postoperative review, she has pronounced menopausal symptoms and asks about hormone replacement therapy.

Competencies tested:

- Preoperative assessment for gynaecological surgery and gynaecological anaesthesia.
- Diagnosis and initiation of management of a woman with abnormal uterine bleeding.
- Understanding of the principles of gynaecological oncology, including surgery, chemotherapy, radiotherapy and palliation.
- Surgical skills. Prepare a specific patient for a specific operation.

## Clinical Risk Management Activity Reflection Worksheet

**Have you attended a meeting or workshop that you wish to claim PR&CRM points for?**

If so this new worksheet is the one for you. It enables you to demonstrate that you have reflected on and reviewed in your practice as a result of attending a particular workshop or meeting. It also provides you with the opportunity to outline any follow-up work undertaken and to comment on plans to re-evaluate any changes made.

Download a form from the College website at:

**[www.ranzcog.edu.au/fellows/prcrmactivities.shtml](http://www.ranzcog.edu.au/fellows/prcrmactivities.shtml)**  
**#RiskManagement**

For further information contact:

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# MRANZCOG

## Written Examination

### August 2009

**Dr Jolyon Ford**  
SAQ Coordinator

The Short Answer Questions (SAQs) are designed to test not only the candidates knowledge, but also their ability to apply this knowledge to typical higher order thinking that is used in everyday obstetric and gynaecological practice. Whilst some questions simply require candidates to list investigations, diagnoses or treatments, others will ask for evaluation, prioritisation, comparisons, or justifications for certain treatments or assessments. Examples of this include the ability to apply evidence or guidelines to unusual clinical situations, or to be able to evaluate the benefits and disadvantages of different treatments.

In this examination, candidates were expected to justify investigations, as well as compare physiological mechanisms and ultrasound modalities. In addition, they were expected to describe the management of a number of common or important conditions and summarise a large international study that has implications for how we all practise obstetrics and gynaecology.

In 2009, the Examination Assessment Committee agreed to provide the whole question to candidates to assist them in their preparation for the exam. This also means that questions are less likely to be repeated in future exams, although the curricular topics may be used as a basis for any future questions. Candidates should review the written information provided on the RANZCOG website for more information on the format of the exam.

What follows is a full transcription of the exam and a few notes to outline the expectations from each question.

#### Question 1 Dysmenorrhoea

An 18-year-old nulliparous sexually active woman presents with a history of disabling dysmenorrhoea which requires her to take time off work each month.

- List the causes of dysmenorrhoea. (2 marks)
  - How would you assess this patient in the outpatient setting? (2 marks)
- Discuss the advantages and disadvantages of hysteroscopy and laparoscopy for this particular patient. (4 marks)
- List the risks of a diagnostic laparoscopy. (5 marks)
- In the absence of any recognisable pathology, what are the management options for this patient? (2 marks)

Other than the routine management of dysmenorrhoea, this question was expecting a realistic line of investigation and

management in a young woman who is unlikely to have any identifiable pathology. Disadvantages of invasive procedures would therefore need to include the high chance of negative findings and this should therefore be balanced against the risk of the procedures.

#### Question 2 Human papillomavirus infection and vaccine

- Outline the association between human papillomavirus (HPV) and cervical malignancy. (5 marks)
- Briefly describe the two HPV vaccines available in Australia and New Zealand. (4 marks)
- National immunisation programs have been introduced in Australia and New Zealand. Who is the vaccine given to and how is it given (describe either the Australian or New Zealand program)? (2 marks)

A 22-year-old woman comes to you with a recent Pap smear report: Low-grade squamous cell lesion consistent with HPV infection. She has not had the HPV vaccination.

- What would you advise her and why? (4 marks)

As a relatively new but widespread issue for young women, candidates were expected to have a detailed knowledge of the HPV vaccine and its program in either Australia or New Zealand. The counselling of a low-grade result should also relate to any previous results, including an opportunity for wider discussion about STI screening, lifestyle changes and the value of HPV vaccination in this young woman.

#### Question 3 Ovulation

- Briefly describe the physiological mechanisms that cause ovulation in the normally cycling woman. (4 marks)
- Compare the hormonal mechanisms of anovulation between women with a pituitary microadenoma and women using a combined oral contraceptive pill. (3 marks)
- Describe the mechanism of action of clomiphene citrate when used in ovulation induction. (4 marks)
- Name the common or important potential side effects of clomiphene therapy. (4 marks)

Candidates were expected to have an understanding of the normal physiological mechanisms that underlie normal reproductive health and the mechanisms of action of common drugs. When asked to compare two mechanisms as requested in this question, rather than simply listing the details, candidates were expected to identify the similarities and differences between the two. For example, pituitary adenoma represents a relatively low estrogenic state, compared to the combined oral contraceptive pill (COCP), which causes a high estrogenic state, but they both suppress pituitary function.

**Question 4****Hysterectomy complication**

A 45-year-old patient underwent total abdominal hysterectomy and bilateral salpingo-oophorectomy for enlarged fibroids. The procedure seemed uncomplicated. One hour post-operatively you are called to see the patient. She is unwell, cold and clammy. She has a pulse of 130 and BP of 90/50mmHg.

- How could you minimise the risk of intraoperative bleeding when performing an abdominal hysterectomy? (3 marks)
- List the anatomical points where this patient could be bleeding. (3 marks)
- Outline your management of this case. (9 marks)

In any question about surgical risk, candidates would be expected to outline any preoperative workup and optimisation required, as well as describing the intraoperative techniques to minimise adverse outcomes. Postoperative management may depend on whether the patient was considered to still be actively bleeding and so would depend on a detailed review of the intraoperative loss, as well as the postoperative status. An outline of how any ongoing bleeding could be arrested after returning to theatre was also expected.

**Question 5****Fertility-sparing management of fibroids**

- List how fibroids may impact on reproduction. (4 marks)

A 32-year-old nulliparous woman with two years of primary infertility and menorrhagia has an ultrasound which suggests a 4cm posterior wall fibroid which is distorting the endometrial cavity.

- What further investigations would you do? Justify each. (4 marks)
- Under what circumstances would you consider a hysteroscopic resection for this patient? (3 marks)

You are performing a hysteroscopic resection of the fibroid. The operation has been going for 50 minutes and the fibroid is only partly removed when the theatre nurse tells you the patient has reached a positive balance of glycine of 3000ml.

- What is your management plan? (4 marks)

It is important to consider all the phases of the reproductive cycle when describing the impact of fibroids, but some candidates only described the impact on advanced pregnancy. Questions on justification of investigations should contain a reason why each investigation would be of value in achieving a diagnosis or excluding other pathology. Simply listing the investigations in this case would be insufficient for achieving full marks. Glycine overload is a rare but life-threatening situation that must be managed appropriately.

**Question 6****Anaemia in pregnancy**

- Outline the benefits and disadvantages of routine iron supplements in pregnancy. (4 marks)
- A 30-year-old woman at 28 weeks gestation in her first pregnancy had a routine full blood count. The results are:
  - Hb 90 g/l (115-150)

- MCV 105 fl (78-101)
- MCH 30 pg (25-35)
- WBC 4.5 x10<sup>9</sup>/l (3.9-10.0)
- platelets 150 x10<sup>9</sup>/l (150-400)
- blood film shows macrocytes and hypersegmented neutrophils

- What condition is likely to be present? (1 mark)
- What further investigations would you arrange to clarify the cause of this blood picture? (3 marks)
- What supplementation should be considered for this patient? (2 marks)
- Other than dietary deficiency, what other causes could produce this type of blood picture? (5 marks)

Anaemia is common in pregnancy. In this question, candidates were also expected to identify the investigation and management of the rarer type of megaloblastic anaemia.

**Question 7****Anhydramnios**

A woman referred to you after the 19-week ultrasound shows a singleton live fetus with anhydramnios.

- Briefly outline the possible causes of anhydramnios in this woman. (3 marks)
- Discuss what history, examination and/or investigations, if any, you require to determine the cause of the anhydramnios. (6 marks)
- Describe the possible outcomes for the mother and fetus. (4 marks)
- What are the management options? (2 marks)

This question was generally answered well, with a focus on ruptured membranes and renal problems. However, many candidates failed to describe that, whilst the outcome was generally poor, not all of these cases will end badly and that continuing the pregnancy with close monitoring is an option that should be discussed. If a tertiary opinion or specialist scan is required, good candidates are expected to outline what the tertiary unit is going to do or what the scan is going to assess, rather than simply referring the patient on.

**Question 8****Abnormal lie**

A 35-year-old G5 P4 woman is seen in your antenatal clinic at 38 weeks gestation with an oblique lie. The past history includes four spontaneous vaginal deliveries (SVDs) at term. Her heaviest baby weighed 3700gm.

- Outline your antenatal plan of management for this patient. (4 marks)
- The lie stabilises and an induction of labour is planned at 40 weeks. She is contracting irregularly. An ARM is performed with controlled release of liquor. Several minutes later a cord prolapse becomes evident. An emergency theatre is immediately available. Describe your management in this situation. (5 marks)
- How would your management differ if you were in a regional hospital at night where it will take 40 minutes to call in staff and open theatres. (3 marks)

*Continued on page 75.*



# Applications invited for new Examiners

Fellows and Diplomates of the College are invited to apply for membership of the College's Board of Examiners.

RANZCOG has only one Board of Examiners from which the Diploma, Membership and Subspecialty Examiners are drawn for each relevant written and oral examination.

There is a Provisional Examiner process that must be followed prior to elevation to the Board of Examiners.

Both Diplomates and Fellows may examine at DRANZCOG level.

Fellows may examine at MRANZCOG level and, if they are currently working in a subspecialty discipline, they may also examine at subspecialty level.

## Duties

Members of the Board of Examiners may participate in the following activities related to the components of their respective examination level:

1. Developing new stations for the oral examinations. This consists of generating initial case summaries and working on the development of cases submitted by other examiners.
2. Participating in oral examinations. This involves participation in a pre-examination workshop immediately before each examination as well as participation in the examination itself, either as an examiner or an observer.
3. Developing new multiple choice questions for the written examinations. This involves writing new questions and/or editing questions submitted by others.
4. Participating in the standard setting panel for the written and oral examinations. This involves working through all of the questions and cases used in an examination and estimating the difficulty of each question.

In addition, Fellows examining at MRANZCOG and Subspecialty level may participate in the following:

5. Developing new short answer questions for the written examination and marking short answer question papers. This involves writing new questions and/or editing questions submitted by others and the assessment of candidate responses against a pre-determined marking scheme.

## Additional information

### Availability

Examiners are expected to be available at least once a year for their designated level examinations.

### Qualifications and Experience

Applications for Membership/Subspecialty must be actively engaged in clinical practice in the speciality. Applicants must be familiar with the current training programs but need not hold an appointment in a teaching hospital. Previous experience in examining at undergraduate and/or postgraduate level is preferred.

### Method of Application

To be considered for an appointment, an application must be submitted to the Education and Assessment Committee. The application form may be obtained from the Assessment Services department at College House by calling +61 3 9417 1699 or by downloading from the College website at [www.ranzcog.edu.au/fellows/examiners.shtml](http://www.ranzcog.edu.au/fellows/examiners.shtml). A current curriculum vitae must accompany a completed application form. Contact details for two referees must also be provided.

### Review of Applications

Applications will be reviewed by the RANZCOG Education and Assessment Committee three times a year (March, July and November). Applicants will be notified in writing of the result of their application.

### Enquiries

Questions regarding application for membership or the duties of examiners should be directed to Frances Gilleard, Assessment Coordinator, Assessment Services, on +61 3 9412 2945 or at [fgilleard@ranzcog.edu.au](mailto:fgilleard@ranzcog.edu.au).

The management of cord prolapse is well-described and candidates were expected to outline the need for immediate delivery after confirming cervical dilatation and the presence of the fetal heart (which were sometimes missed). Candidates were expected to know that emergency situations may need to be managed differently according to different local resources. Methods such as filling the bladder and tocolysis should be considered if a delay is expected.

### Question 9 Adnexal mass in pregnancy

A previously well 32-year-old nullipara at eight weeks gestation is incidentally found to have a 7cm right adnexal mass of mixed echogenicity on her dating ultrasound scan.

- What is the differential diagnosis? (4 marks)
- Outline what investigations you would arrange. (4 marks)
- Detail your management strategy for this woman including the pros and cons of surgery. (7 marks)

Adnexal masses in pregnancy can pose a management dilemma and require thorough evaluation, counselling, surveillance and finally a decision on whether to operate. Candidates were expected to provide a detailed outline of all of these aspects for full marks.

### Question 10 Medications in pregnancy/radiation exposure in pregnancy

A patient is referred to you at 12 weeks of pregnancy, concerned about medication use in pregnancy. She has been on paracetamol (category A), prochlorperazine (stemetil) (category C), and phenytoin (category D).

- For each of these drugs, explain what the categorisation means in regard to safety and what your advice would be regarding their continuation in pregnancy. (6 marks)
- Another patient has had diagnostic imaging in pregnancy. What information would you need to obtain to assess the risk to the fetus from radiation exposure in pregnancy? (3 marks)
- What are the possible effects of diagnostic ionising radiation on the fetus (for example, CT or x-ray)? (4 marks)
- A patient has had a CT chest at eight weeks gestation. How would you advise her in regard to fetal radiation risk? (2 marks)

Candidates were expected to have a detailed understanding of the pharmaceutical categories and to be able to outline what advice they would give to the patient regarding each of the drugs listed. Some candidates did not answer the full question in this respect. They were expected to be generally reassuring about the risk from a CT at eight weeks gestation.

### Question 11 Preterm PROM and Oracle

A primiparous woman presents to you at 32 weeks gestation with spontaneous rupture of membranes. Her pregnancy has been uncomplicated so far and she is well.

- Outline what assessments you would perform. (3 marks)
- Assuming your investigations are normal, how would you manage her? (5 marks)

The Oracle I trial (Kenyon *et al.* Lancet 2001; 357: 979-88) studied women with preterm prelabour rupture of membranes.

- Briefly describe the study and its principle findings (numerical statistics not required). (4 marks)

The Oracle II study (Kenyon *et al.* Lancet 2001; 357: 989-94) used the same treatment options as Oracle I.

- How did the group of women that was studied differ from the Oracle I group? (1 mark)

Both studies had their seven-year follow-up data published in 2008 (Kenyon *et al.* Lancet 2008; 372: 1310-27).

- What additional information did this follow-up provide (numerical statistics not required)? (2 marks)

The Oracle trial has made a significant contribution to our knowledge of the management of preterm rupture of membranes and preterm labour. Candidates were expected to have knowledge of the principles of the paper and the recent follow-up data that raises further questions about the use of antibiotics in preterm labour.

### Question 12 Postmenopausal bleeding

Mary Smith is a 54-year-old woman presenting with recent onset of vaginal bleeding. Her last period was four years earlier. Mary is obese (BMI 33). She is otherwise well and has not been taking any medication or over-the-counter therapies. Bimanual pelvic examination is normal. Her last Pap smear was 18 months ago and was normal.

- Mary is concerned that she has cancer. What are you going to advise her in the outpatient setting? (3 marks)
- List and briefly compare three modalities of ultrasound evaluation of the endometrium in relation to this presentation. (3 marks)
- Briefly compare and contrast the role of outpatient endometrial sampling (such as Pipelle) versus formal hysteroscopy, dilatation and curettage with reference to the differential diagnosis of endometrial carcinoma in this presentation. (4 marks)

The histopathology of the endometrium shows 'complex atypical endometrial hyperplasia'.

- Briefly discuss the significance of this report and the likely pathogenesis in this patient. (2 marks)
- List the management options available for Mary. (3 marks)

Ultrasound is often used to investigate this condition, but there are different routes (vaginal versus abdominal), technologies (doppler, 3D) and additional techniques (saline contrast) that candidates could discuss here. Comparing investigations in this setting requires a summary of the advantages and disadvantages of each investigation, which could include a description of ease of use, accuracy, cost, acceptability, etc. Candidates were expected to describe the cause and implications of hyperplasia and summarise the management options.

# Future directions for CPD

**Dr Louise Farrell**  
FRANZCOG

**RANZCOG has been at the forefront of continuing professional development (CPD) programs amongst the Australian and New Zealand medical colleges, with Fellowship linked to a mandatory program of continuing education and recertification since 1986.**

Some 20 years later, RANZCOG remains committed to ensuring the CPD program is relevant, valid and achievable for the wide variety of practice embraced by College Fellowship. The RANZCOG CPD program should be able to guide and support obstetricians and gynaecologists in maintaining and improving the currency of their knowledge and practice, to provide the highest possible standards of care to women, as well as being able to meet any regulatory requirements that arise.

The College has been ahead of legislative requirements in the structure of our program. However, changes in requirements for CPD and continuing assessment of medical competency are occurring around the world, including in Australia and New Zealand.

## What's happening in Australia?

In March 2008, the Council of Australian Governments (COAG) agreed to introduce a single national registration and accreditation scheme for health professionals in Australia. The national registration process should commence on 1 July 2010 and will be implemented by the Medical Board of Australia. The functions of the Board are listed on the website at: [www.medicalboard.gov.au](http://www.medicalboard.gov.au).

### The functions of the Medical Board of Australia include overseeing:

- The registration of medical practitioners
- The development of professional standards for medicine
- Handling notifications and complaints about medical practitioners
- Assessment of International Medical Graduates who wish to practise in Australia.

In December 2009, the Board submitted proposals for mandatory registration standards and specialist recognition to the Australian Health Workforce Ministerial Council. The proposals submitted contain registration standards related to:

- Criminal history
- English language requirements
- Professional indemnity insurance arrangements
- Continuing professional development
- Recency of practice
- Specialist registration.

As a result of these proposals, CPD will now be a mandatory standard for registration across Australia. Some of the State medical boards already have this requirement for registration.

In July 2009, the Australian Medical Council (AMC), in association with the State and Territory medical boards, released a report titled *Good Medical Practice: A Code of Conduct for Doctors in Australia*. At the third meeting of the Australian Medical Board in November 2009, the Board decided it would publish this document as the draft code of the Medical Board of Australia on its website. It would invite submissions before considering whether to approve *Good Medical Practice* as the code under the national legislation that will apply to the medical profession in Australia.

*Good Medical Practice* can be accessed at: [www.medicalboard.gov.au](http://www.medicalboard.gov.au). It contains 11 sections. *Section 6 Minimising Risk* and *Section 7 Maintaining Professional Performance* particularly relate to the CPD program. The key elements as they relate to CPD follow.

## Section 6. Minimising Risk

### 6.1 Introduction

Risk is inherent in healthcare. Minimising risk to patients is an important component of medical practice. Good medical practice involves understanding and applying the key principles of risk minimisation and management in your practice.

### 6.2 Risk management

Good medical practice in relation to risk management involves:

- 6.2.1 Being aware of the importance of the principles of open disclosure and a non-punitive approach to incident management.
- 6.2.2 Participating in systems of quality assurance and improvement.
- 6.2.3 Participating in systems for surveillance and monitoring of adverse events and 'near misses', including reporting such events.
- 6.2.4 If you have management responsibilities, making sure that systems are in place for raising concerns about risks to patients.
- 6.2.5 Working in your practice and within systems to reduce error and improve patient safety, and supporting colleagues who raise concerns about patient safety.
- 6.2.6 Taking all reasonable steps to address the issue if you have reason to think that patient safety may be compromised.

## Section 7. Maintaining Professional Performance

### 7.1 Introduction

Maintaining and developing your knowledge, skills and professional behaviour are core aspects of good medical practice. This requires self-reflection and participation in relevant professional development, practice improvement and performance-appraisal processes, to continually develop your professional capabilities. These activities must continue throughout your working life, as science and technology develop and society changes.

### 7.2 Continuing professional development

Development of your knowledge, skills and professional behaviour must continue throughout your working life. Good medical practice involves:

- 7.2.1 Keeping your knowledge and skills up to date.
- 7.2.2 Participating regularly in activities that maintain and further develop your knowledge, skills and performance.
- 7.2.3 Ensuring that your practice meets the standards that would be reasonably expected by the public and your peers.
- 7.2.4 Regularly reviewing your continuing medical education and continuing professional development activities to ensure that they are consistent with those recommended by your professional organisation and regulatory authorities.
- 7.2.5 Ensuring that your personal continuing professional development program includes self-directed and practice-based learning.

### New Zealand experience

In July 2001, the New Zealand Medical Council (NZMC) required all vocationally registered medical practitioners to indicate on their annual registration form the recertification (CPD) program in which they were participating. In 2003, the NZMC required that all registered medical practitioners participate in an approved recertification program; the RANZCOG CPD program meets the NZMC's criteria.

The NZMC specifies that recertification must include:

- Audit, peer review and team-based assessment to verify that individual practitioners practise competently, for example:
  - External audit of procedures
  - Quality assurance activity
  - Peer review of cases, review of charts, practice visits
  - Analysis of patient outcomes
- Educational conferences, courses and workshops
- An understanding and respect of cultural competence.

The NZMC has expressed interest in the New Zealand Practice Visit program and is considering introducing regular practice visits by peers (perhaps every five or ten years) as a recertification requirement.

### Changes in the United Kingdom

Australia and New Zealand are not alone in having increasing regulation of medical registration. Last year in the UK, the Government introduced a requirement that all doctors wishing to practice medicine in the UK hold a Licence to Practice. This is in addition to their General Medical Council (GMC) registration.

The Licence to Practice involves a comprehensive assessment of every doctor's continued fitness to practice. This process will be known as revalidation and involves periodic review (normally every five years) that the doctor is practising in accordance with agreed standards. This revalidation process will require specialists and GPs to demonstrate that they continue to meet the particular standards that apply to their specialty or area of practice. Doctors must participate in a CPD program and an appraisal undertaken at the place of employment, encompassing the four domains of the GMC Good Medical Practice: knowledge, skills and performance; safety and quality; communications, partnership and teamwork; and maintaining trust. Further information about this can be accessed from the GMC website: [www.gmc-uk.org](http://www.gmc-uk.org). You can access their document titled *Recertification in Obstetrics and Gynaecology – Report of a Working Party* on the RCOG website: [www.rcog.org.uk](http://www.rcog.org.uk).

### Developments at RANZCOG

It is against this background of increased regulation and scrutiny of CPD, governance and recertification in Australia, New Zealand and overseas, that the CPD Committee has reviewed the College CPD program. An extraordinary meeting of the CPD Committee was convened in July 2008 to examine issues associated with the CPD program and in particular, Practice Review and Clinical Risk Management (PR&CRM) issues. In 2009, the CPD Committee established a working party to further consider issues related to PR&CRM activities. As a result of these meetings, a number of initiatives have recently been implemented and a number are under further review.

### Trial of online CPD program

It was agreed to trial online, a revised CPD program aligning the current program to the RANZCOG Curriculum. The current paper-based CPD program is structured around different types of activities such as meetings attendance and self-education, rather than being directly linked to clinical practice or to the fundamental clinical competencies such as those described in the RANZCOG

Curriculum and on which attainment of Fellowship is based. It was felt that the revised program would enable Fellows to choose activities that are directly linked and relevant to their current practice, providing a sound framework of clinical professionalism on which to base continued development and maintenance of knowledge, skills and abilities to better suit professional needs.

Fellows beginning the first year of their certification triennium in 2009 were invited to participate in a 12-month online pilot, beginning in September 2009. Approximately 50 Fellows are currently trialing the revised framework, which involves the submission of an online learning plan to help identify one's educational and professional needs at the beginning of the cycle. By doing this, Fellows are encouraged to plan their learning across a range of professional domains, as well as taking advantage of opportunistic learning that inevitably arises.

It is envisaged that the revised program will continue to be a minimum of 150 hours of CPD over three years, with 25 of these hours in the area of Practice Review and Clinical Risk Management. Currently, Fellows undertake a variety of activities in the PR&CRM area and this will continue to be encouraged and strengthened, particularly in the light of increasing regulation and medical board requirements.

### Practice Review and Clinical Risk Management

In College documentation, Practice Review (PR) is seen as a quality improvement process that aims to improve a Fellow's patient care and outcomes through clinical audit. Clinical Risk Management (CRM) refers to measures to improve safe practice and/or minimise harm and is a tool for improving quality of care.

Currently, in the RANZCOG CPD program, both are separately defined but are under the same 'umbrella'. Both groups of activities are considered important and a necessary part of point acquisition.

One of the considerations of the recent working party meetings is that all Fellows should undertake a clinical audit of an aspect of their practice following the Quality Cycle, within each CPD period, as well as activities that are considered to have a clinical risk management focus. However, whilst it has been agreed that audit should be a mandatory part of PR, it is recognised that not all Fellows have ready access to the necessary tools. Some Fellows are fortunate enough to work in hospitals that provide robust audit systems. If the infrastructure for audit is already provided, it is not envisaged that a Fellow should be required to duplicate this. It is, however, important to examine whether what we think is happening really is, and whether current performance meets existing standards. Reflection is an important component of an audit as well as an action plan for any changes in practice, if and where appropriate.

For those unfamiliar with the audit process or where audit may be seen too difficult to organise, the CPD Committee is eager to provide resources and to develop access to a suite of suitable tools that Fellows can use for performing audits. The committee is cognisant that engagement in surgical practice is not universal through the Fellowship and a wide range of tools must be available to suit the diversity of practice within our specialty before this requirement is introduced.

One of the tools that Fellows can currently access is a surgical audit tool recently developed by one of our Fellows, Professor Andreas Obermair, who is a gynaecologic oncologist from Brisbane. Further information about this audit tool can be found in this issue of *O&G Magazine* (see page 54 and 55) and online at: <http://surgicalperformance.com>.

*Continued on page 79.*





RANZCOG  
Research Foundation

## DID YOU KNOW?

### RANZCOG RESEARCH FOUNDATION FACT SHEET

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- The RANZCOG Research Foundation encourages and supports research in the fields of obstetrics, gynaecology, women's health and reproductive sciences and specifically provides support for scientific and clinical research through research fellowships, scholarships and travel grants. The Foundation especially supports the development of the research careers of trainees and early career Fellows of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG).
- The RANZCOG Research Foundation works closely with the RANZCOG Executive, Council and Council Committees to further the needs for research and research training in the broad fields of obstetrics, gynaecology, women's health and reproductive sciences.
- For almost 50 years, the RANZCOG Research Foundation has been supporting research training for promising young Australian Fellows and scientists who undertake high quality research and research training at an early stage of their careers.
- The RANZCOG Research Foundation disburses approximately \$120,000 annually towards basic and advanced research training in obstetrics, gynaecology and in women's health.
- Scholars have a strong record of subsequent achievement in research and in academic careers in Australia and overseas.
- The RANZCOG Research Foundation has sponsored young Fellows and scientists in undertaking innovative research in a number of exciting projects in recent years. For example, stem cells from human endometrium.
- The RANZCOG Research Foundation recently made the decision to enhance its support for RANZCOG trainees in their research endeavours during the FRANZCOG training program.

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**Helping to drive research excellence in women's health**

RANZCOG Research Foundation (ABN 23 004 303 744)

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In New Zealand, the Ministry of Health has produced a guide to clinical audit, peer review and other clinical practice improvement activities, titled *Towards Clinical Excellence*. It can be accessed on the New Zealand Ministry of Health website at: [www.moh.govt.nz](http://www.moh.govt.nz).

The CPD Committee is eager to hear from Fellows who have already developed audit tools and resources or who have been involved in audits that could be adopted or adapted by other RANZCOG Fellows. For example, those that may involve a total practice or workload audit; an audit that covers all patients who undergo a selected procedure or is craft specific; an audit that covers all procedures conducted within a selected time-frame; an audit conducted by a clinical unit in which individuals may participate; or a focused audit that perhaps looks at one or more of the RANZCOG/ACHS Obstetric and Gynaecology Indicators.

#### **PR&CRM points associated with meetings**

Meetings and workshops that previously automatically attracted PR&CRM points because of their focus, will continue to do so and are listed on the College website at: [www.ranzcog.edu.au/fellows/prcrmactivities.shtml](http://www.ranzcog.edu.au/fellows/prcrmactivities.shtml).

From January 2010, however, meetings and workshops that previously attracted PR&CRM points through the use of pre and post multiple choice questions (MCQ) will no longer be eligible to do so. In their place, a set of criteria has been developed for organisers of workshops and meetings who may wish to have their activity accredited as a PR&CRM activity.

In addition, Fellows can claim PR&CRM points for attendance at a general meeting or workshop if they complete a reflection worksheet that has been designed for this purpose. The reflection should begin by identifying a need or requirement in the Fellow's practice for the information/skills acquired at the meeting. Then after the meeting, reflecting on how/what will change in the practice as a result of attending the meeting and finally documenting how and when the impact of these changes will be assessed.

With increasing scrutiny of clinical performance by governments and regulatory bodies, it is essential that the RANZCOG CPD program continues to satisfy their requirements. It can only do so by demonstrating that it is a robust program that serves the aim of promoting improved patient care and safety. It must adapt to the current heavy reliance on electronic media and ensure that it offers the resources and structure to enable the entire Fellowship to embrace and benefit from the RANZCOG CPD program.

#### **Summary**

- CPD is your responsibility.
- CPD is a mandatory registration requirement of the new Medical Board of Australia.
- CPD is a mandatory registration requirement of the New Zealand Medical Council.
- Audit of some aspect of your practice will be a mandatory part of your PR&CRM requirements for RANZCOG.
- Clinical Risk Management (CRM) refers to measures that improve safe practice and minimise harm.
- New criteria have been developed for organisers of workshops and meetings to receive accreditation as PR&CRM activities.
- New online tools are available and more are under development to assist you in these processes.
- A survey of the Fellows will be undertaken to assess their current practice in regard to clinical practice audit.

#### **Acknowledgements**

I would like to acknowledge that much of the substance of this article has been derived from documents provided to me by College staff or documents produced by them for discussion at various College meetings about CPD. I would particularly like to thank Valerie Jenkins, Val Spark and Lyn Johnson. In addition, I would like to especially thank my friend and colleague, Professor Ian Hammond, for his invaluable support and advice and for chairing the subcommittee working party meetings on PR&CRM. My gratitude goes to the entire CPD Committee, especially Associate Professor Glyn Teale, Dr Chris Hughes and Associate Professor Les Reti, who served on the subcommittee.

## **Are you registered on the RANZCOG website under our 'locate an obstetrician/gynaecologist' link?**

**Can your colleagues locate you for referral purposes?**

**On the College website, two 'Register of Fellows' are published: a publicly accessible register of active Fellows in Australia and New Zealand and a restricted access register of all College members.**

**The PUBLICLY ACCESSIBLE 'Register of Active Fellows' lists your work address, phone number and brief practice details (for example, private and/or public obstetrics and gynaecology or area of subspecialty).**

**The RESTRICTED ACCESS 'Membership Register' lists the work contact details of members of the College who wish to be included and is accessible only by members of the College who have a website user name and password.**

**If you would like your work contact details to be included on either or both of the registers and/or would like to update your details already listed on the website, please contact:**

**Tracey Wheeler  
(t) +61 3 9417 1699  
(e) [reception@ranzcog.edu.au](mailto:reception@ranzcog.edu.au)**

# College Statements Update

## November 2009



**Michael Permezel**  
FRANZCOG  
Chair, Women's Health  
Committee

**The Women's Health Committee (WHC) approved three new statements in November 2009, which were subsequently endorsed by Council. New and revised College statements can be viewed on the College website at: [www.ranzcog.edu.au/womenshealth/statementsupdate.shtml](http://www.ranzcog.edu.au/womenshealth/statementsupdate.shtml) .**

### New College Statements

#### **C-Gen 15: Evidence-based Medicine in Obstetrics and Gynaecology**

Fundamental to the practice of obstetrics and gynaecology is an appreciation of available evidence. Whilst acknowledging that for some clinical situations a randomised controlled trial (RCT) may be the most important evidence to consider, the

statement emphasises that other evidence may be more applicable – particularly where the outcome is clinically important at low frequency. It is also important not to overlook consideration of the individual and local circumstances in the application of evidence that may be drawn from a dissimilar or diverse population – particularly when trial numbers are large.

#### **C-Gen 14: Guidelines for Performing Robotic Surgery**

With the increase of robotic surgery in gynaecological surgery, this statement addresses the need for minimum standards in relation to training, practice, skill acquisition and the understanding of the appropriate equipment. The committee is grateful to Dr Anusch Yazdani for assistance in developing this statement.

#### **C-Gen 29a: Progesterone Support of the Luteal Phase and Early Pregnancy**

This statement was produced with the assistance of Dr Mark Bowman, Chair of the REI subcommittee. It considers the use of progesterone for the management of recurrent miscarriage where there may be benefit in some patients and in assisted reproduction where the evidence of benefit is substantive.

### Revised College Statements with Significant Amendments

#### **C-Obs 3: Pre-pregnancy Counselling and Routine Antenatal Assessment in the Absence of Pregnancy Complications**

A section on pre-pregnancy counselling has been added to the previously endorsed antenatal assessment statement. The imperative of thorough clinical assessment with a detailed history and clinical examination has been emphasised. Recommendations for 'routine' prenatal and antenatal investigation are included in this statement.

#### **C-Obs 11: Management of the Term Breech Presentation**

A paragraph concerning intrapartum management of the undiagnosed breech presentation has been added to this statement. Quality antenatal care, including ready access to obstetric

ultrasound, should minimise this occurrence. However, there will still be pregnancies where the breech presentation is first diagnosed in labour.

#### **C-Obs 13: Rotational Forceps**

This remains an important College statement. Reviews of Kielland's forceps have consistently found a place for their use. New references from the *Australian and New Zealand Journal of Obstetrics and Gynaecology (ANZJOG)* articles in 2009 have been added to this statement.

#### **C-Obs 14: Categorisation of Urgency for Caesarean Section**

This statement was previously titled: Decision to Delivery Interval for Caesarean Section. Amongst important additions to this statement is the necessity of hospitals delivering intrapartum care to be adequately resourced to meet the requirements of the RANZCOG categorisation; subjecting the caesarean section decision to delivery interval (DDI) to regular audits; and recommending that staff allocated to emergency obstetric cases receive the necessary specific training.

#### **C-Obs 18: Umbilical Cord Blood Banking**

Dr Digby Ngan Kee assisted with several amendments to this statement. Assisting patients make decisions on private cord blood banking necessitates knowledge of the likelihood and nature of any future benefit and the resources to be allocated.

#### **C-Gen 3: Hepatitis B and C-Gen 4: Hepatitis C**

The College has re-endorsed its view that screening for hepatitis V virus (HCV) antibody should be recommended to all pregnant women. Other key recommendations with respect to hepatitis C include: individuals who are HCV positive should have a PCR test for HCV RNA and liver function tests; consideration of HCV status when contemplating invasive procedures in pregnancy or labour; and appropriate follow-up of HCV positive women and their offspring. Thanks are extended to Dr Tom Cottee for his assistance in reviewing both College statements.

#### **C-Gyn 21: The Use of Mifepristone for Medical Termination of Pregnancy**

The review incorporated relevant sections of the previous College statement C-Gyn 14, which has now been retired.

#### **WPI 3: Policy on Prejudicial Relationships**

With the agreement of the Women's Health Committee, the College Training Accreditation Committee substantially revised this policy to clarify wording, in response to feedback received from Trainees and supervisors, and also to make it applicable to all groups of Trainees, therefore, those from the ITP/Elective, Subspecialties and Diploma training programs.

## Revised College Statements Endorsed Without Significant Changes

- C-Obs 9: Standards for Epidural/Spinal Anaesthesia in Obstetric Practice
- C-Obs 10: Neonatal Male Circumcision
- C-Obs 16: Instrumental Vaginal Delivery
- C-Obs 19: RANZCOG/RACGP Joint Statement on Pap Smears
- WIP 5: Hospital Access for the Practice of Obstetrics by General Practitioner Obstetricians and Rural Non-specialist Obstetricians in Australia
- WIP 6: Guidelines for the Assistance of Hospital Committees in the Delineation of Credentials and Scope of Clinical Practice for General Practitioner Obstetricians and Rural Non-specialist Obstetricians Practising Obstetrics in Australia
- WIP 9: Policy Statement on Shared Maternity Care Obstetric Patients in Australia

## New Statements Under Development

- Long-term health consequences of polycystic ovarian syndrome (PCOS)
- Progesterone use in second and third trimesters of pregnancy
- Screening for genetic conditions

## H1N1 Influenza: Information for Fellows

RANZCOG's current H1N1 influenza pandemic webpage has been recently updated. The College will continue to provide current information on its website that we hope will assist Fellows in the management of their patients. Go to: [www.ranzcog.edu.au/womenshealth/pregnancy-influenza.shtml](http://www.ranzcog.edu.au/womenshealth/pregnancy-influenza.shtml) .

# C-Gen 14: Guidelines for Performing Robotic Surgery

**Date of this document:** November 2009

**First endorsed by Council:** November 2009

**Next review due:** November 2012

### Preamble

Robotic surgery is defined as the use of a fixed or mobile automatically controlled, multipurpose manipulator reprogrammable in three or more axes, to assist in surgical procedures. The patient and surgeon may be separated from the procedure by a master slave telerobotic system, which allows the surgeon to perform the operation in a remote location.

### Guideline

Robotic procedures fall under the auspices of minimally invasive surgery and are considered advanced laparoscopic surgical procedures. Robotic surgery has been explored in a number of procedures and may be an acceptable form of treatment for a variety of conditions. At the time of this statement, there is insufficient evidence to determine the safety or efficacy of robotic surgery compared to other minimally invasive procedures.

Robotic surgery has specific risks and hazards that require guidelines for minimum standards in relation to training, practice, skill acquisition and the understanding of the appropriate equipment.

## RANZCOG Application Aide for TGA Authorised Prescriber Status for Mifepristone

For those seeking to become an authorised prescriber for Mifepristone, the College has developed an application aide to assist you with the process. If you would like a copy of the aide to be emailed to you, contact RANZCOG: (t) +61 3 8415 0408.

## College Website

### College Statements

Can be viewed at: [www.ranzcog.edu.au/womenshealth/statementsupdate.shtml](http://www.ranzcog.edu.au/womenshealth/statementsupdate.shtml) . During January 2010, RANZCOG's Women's Health webpage underwent significant change in the area of College statement and guideline listings and presentation. Should you have any difficulties with any documents from the webpage, please contact Nola Jackson at the College: (t) +61 3 8415 0408 (e) [njackson@ranzcog.edu.au](mailto:njackson@ranzcog.edu.au) .

### Resources for Fellows

This section includes local and international guidelines and articles of interest, such as links to new titles on ACOG Committee Opinions and Practice Bulletins, SOGC Clinical Guidelines, National Institute of Clinical Excellence (NICE) guidelines and Department of Health and Ageing reports. Access at: [www.ranzcog.edu.au/locked/members/fellowsresources.shtml](http://www.ranzcog.edu.au/locked/members/fellowsresources.shtml) . Type in your username and password and scroll down to 'Information from Women's Health Services'.

It is recommended that gynaecologists do not perform robotic surgery until they have reached appropriate skill levels in advanced operative laparoscopy. Credentialing of robotic surgeons is undertaken by individual hospitals or regional credentialing committees who should refer to the guidelines in this document. In particular, credentialing bodies need to understand that robotic surgical skills do not fall within the general ambit of credentialing for gynaecological surgery and need to be acknowledged as advanced skills.

It is appropriate that robotic surgery only be performed independently by individuals credentialed for a minimum of RANZCOG Skill Level 5 for Advanced Operative Laparoscopy and provide evidence of on or off-site robotic surgery training. Applicants for credentialing in this area should therefore provide proof of suitable training and skills until appropriate centres of excellence have arisen in Australia.

### References

None available

### Links to Other Related College Statements

- C-Trg 2: Guidelines for Performing Advanced Operative Laparoscopy
- C-Gen 2: Guidelines for Consent and the Provision of Information Regarding Proposed Treatment.



# C-Gen 15: Evidence-based Medicine, Obstetrics and Gynaecology

**Date of this document:** November 2009

**First endorsed by Council:** November 2009

**Next review due:** November 2012

RANZCOG endorses the principles of evidence-based medicine and recognises the National Health and Medical Research Council (NHMRC) levels of evidence and grades of recommendations.<sup>1,2,3</sup>

Adverse outcomes in obstetrics, whilst often of very low incidence, still occur at frequencies that may be of clinical importance to some or most women.<sup>4</sup> Where such rare outcomes are the endpoints, the numbers required for meaningful analysis study are necessarily massive. In these situations, case-control or population studies may provide more useful evidence than an under-powered randomised controlled trial (RCT) or an RCT that is undermined by sub-optimal trial circumstances that often become necessary in order to achieve the numbers required.<sup>5</sup>

Not all clinical recommendations lend themselves to assessment by randomised controlled trials, or even case-control, cohort or population studies. Sometimes the evidence is such that subjecting the matter to direct investigation is inappropriate or unnecessary. Gordon Smith's analogy with 'use or non-use of the parachute' has been widely quoted as an example<sup>6</sup>, but the case for some medical treatments may be equally obvious based on only a small number of cases, or even a compelling rationale.<sup>7</sup> In management of rare clinical events, case reports, anecdote and an individual's judgement and experience may legitimately influence decision-making and management plans.

With all levels of evidence (I-IV), recommendations are ultimately made by individuals or panels who use their expertise in the field of practice, or in the interpretation of evidence, to make recommendations from that evidence. Such recommendations cannot be regarded as scientific evidence per se. They are inevitably positions reached by consensus in response to the evidence

assessed, the priorities and expertise of those involved, and a given clinical context. As a result, it is not surprising that individuals and panels come to contrary recommendations arising from the same body of evidence.

In the application of clinical guidelines, it is important that clinicians retain discretion to adapt guidelines to the specific circumstances of individual patients. No guideline can anticipate all clinical scenarios and every local circumstance. It is imperative that guideline implementation allows the clinician to retain some flexibility in the management recommended to patients.

## References

1. NHMRC. How to use the evidence: assessment and application of scientific evidence. Access at: [www.nhmrc.gov.au/publications/synopses/\\_files/cp69.pdf](http://www.nhmrc.gov.au/publications/synopses/_files/cp69.pdf).
2. NHMRC additional levels of evidence and grades for recommendations. Access at: [www.nhmrc.gov.au/guidelines/\\_files/Stage Consultation Levels and Grades.pdf](http://www.nhmrc.gov.au/guidelines/_files/Stage%20Consultation%20Levels%20and%20Grades.pdf).
3. Craig J, Irwig L and Stockler M. Evidence-based medicine: useful tools for decision-making. *MJA* 2001; 174: 248-253.
4. Walker SP, McCarthy EA, Ugoni A, Lee A, Lim S, Permezel M. Cesarean delivery or vaginal birth: a survey of patient and clinician thresholds. *Obstet Gynecol.* 2007 Jan; 109(1):67-72.
5. Glezerman M. Five years to the term breech trial: the rise and fall of a randomized controlled trial. *Am J Obstet Gynecol.* 2006 Jan; 194(1):20-5.
6. Smith GCS, Pell JP. Parachute use to prevent death and major trauma related to gravitational challenge: systematic review of randomized controlled trials. *BMJ* 2003; 327:20-7 pp 1459-61.
7. Diaz M, Neuhauser D. Heroes and martyrs of quality and safety. Pasteur and parachutes: when statistical process control is better than a randomized controlled trial. *Quality and Safety in Health Care* 2005; 14:140-143; doi:10.1136/qshc.2005.013763.

# C-Obs 29: Progesterone Support of the Luteal Phase and Early Pregnancy

**Date of this document:** November 2009

**First endorsed by Council:** November 2009

**Next review due:** November 2012

The following statement is based on a literature search for systematic reviews of randomised controlled trials concerning the role of progesterone or progestin luteal support in various contexts.

For threatened miscarriage, there is no evidence that vaginal progesterone reduces the risk of pregnancy loss, however, this is based on two RCTs in which only 84 women were randomised.<sup>1</sup> Further randomised studies are therefore needed. There was no evidence of benefit of progestin for prevention of miscarriage in an

unselected population based on 15 RCTs including 2118 women.<sup>2</sup> However, sub-group analysis of four of the 15 RCTs, which included 223 women with recurrent miscarriage (three or more consecutive miscarriages), showed the odds of miscarriage were significantly decreased by progestin treatment (Peto OR 0.38, 95% CI 0.20 to 0.70)<sup>2</sup>. However, the studies were clinically heterogeneous (varied, particularly in their treatment regimes). Treatments were a composite of oral progestin (dydrogesterone in one RCT; medroxyprogesterone in another RCT) and intramuscular progesterone in two other RCTs. In addition, the duration of treatment was also highly variable, ranging from a single dose prior to ten weeks to continual treatment through to 36 weeks gestation.<sup>2</sup>

For luteal support in assisted reproductive technologies (ART), hCG (human chorionic gonadotrophin) or progesterone gives a significantly higher pregnancy rate than placebo or no treatment. There is no evidence of a difference in pregnancy rate between hCG and progesterone. hCG is associated with significantly higher rates of the complication ovarian hyperstimulation syndrome (OHSS).<sup>3</sup> Limited evidence suggests intramuscular administration of progesterone may be associated with a higher pregnancy rate than vaginal administration<sup>4</sup> and limited evidence that addition of oral estrogen to progesterone may improve pregnancy rates.<sup>4</sup> Standard current luteal support in most units involves the use of intramuscular hCG or vaginal or intramuscular progesterone and some fertility units use additional oral estrogen in selected cases.

Use of any hormonal treatment in the luteal phase and in early pregnancy must always be used with great caution owing to the possibility of teratogenesis. Unproven treatments should be avoided. The evidence supporting progestin use for preventing recurrent miscarriage must be viewed cautiously owing to the heterogeneity in

treatment regimes that were pooled for this meta-analysis. Ongoing research to provide yet stronger evidence is encouraged.

#### References

1. Wahabi HA, Abed NF, Elawad M. Progestogen for treating threatened miscarriage. *Cochrane Database Syst Rev.* 2007; 3: CD005943.
2. Haas DM, Ramsey PS. Progestogen for preventing miscarriage. *Cochrane Database Syst Rev.* 2008; 2: CD003511.
3. Daya S, Gunby JL. Luteal phase support in assisted reproduction cycles. *Cochrane Database Syst Rev.* 2004; 3: CD004830 (withdrawn).
4. Pritts EA, Atwood AK. Luteal support in infertility treatment: a meta-analysis of the randomized trials. *Hum Reprod.* 2002; 17: 2287-99.

## APPLICATIONS FOR SUBSPECIALTY TRAINING POSITIONS FOR 2011

Applications are invited from prospective Trainees for the RANZCOG subspecialty training programs, which lead to certification in one of the subspecialties:

Gynaecological Oncology (CGO), Obstetrical & Gynaecological Ultrasound (COGU), Maternal Fetal Medicine (CMFM), Reproductive Endocrinology & Infertility (CREI) and Urogynaecology (CU).

**Applicants should note that all subspecialty training positions are subject to availability.**

#### To be eligible for these training programs:

Applicants must have satisfactorily completed the Membership examinations at the time of interview, and by the beginning of 2011 have completed all requirements for the MRANZCOG, one elective year, or hold the FRANZCOG qualification. Trainees in the new Curriculum should note that only one year of post-Membership subspecialty training can be credited toward the particular subspecialty training program.

**All applications must be submitted using the National Selection Process 2011 application form available on the College website at [www.ranzcog.edu.au/trainees/subspecialty-nationalselection.shtml](http://www.ranzcog.edu.au/trainees/subspecialty-nationalselection.shtml) .**

**Please note that you are required to provide the details of three referees. These three referees must be:**

- a) A senior colleague (FRANZCOG or equivalent) with whom you have worked in the previous two years. If you are currently in a training program, this senior colleague **must** be your Training Supervisor.
- b) Two other colleagues of your choice with whom you have worked in the last two years.

**Submit your completed application form to College House addressed to the Chair of the relevant subspecialty committee:**

RANZCOG, College House  
254-260 Albert Street  
East Melbourne  
Victoria 3002, Australia

#### For more information:

Contact Lyn Johnson  
(t) +61 3 9412 2944  
(f) +61 3 9419 7817  
(e) [ljohnson@ranzcog.edu.au](mailto:ljohnson@ranzcog.edu.au)

Further information about the training programs can also be viewed on the College website at [www.ranzcog.edu.au](http://www.ranzcog.edu.au) .  
Applications for all positions close on Friday, 26 March 2010.

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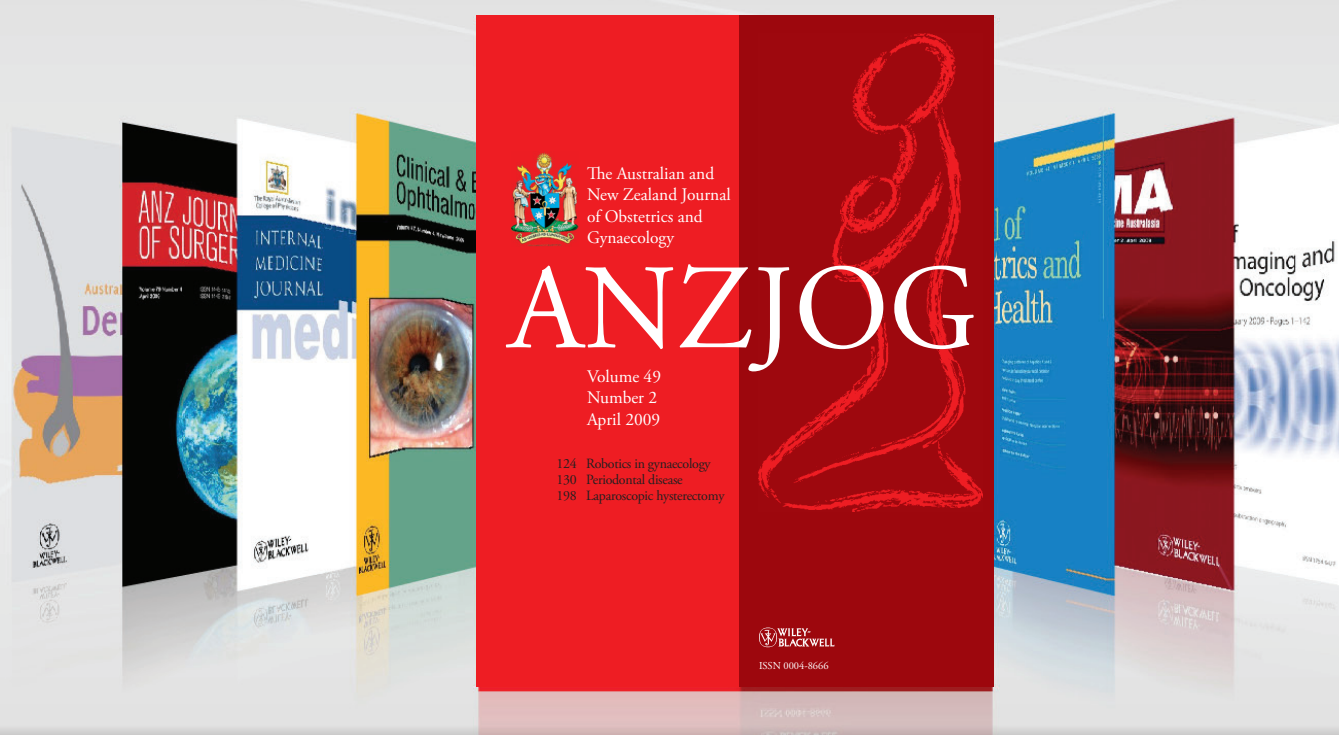
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# Council Meeting Report

## 20 November 2009

### Penelope Griffiths

Director of Corporate Services

### Honorary Fellowship, Indian College of Obstetricians and Gynaecologists (ICOG)

The President reported that Professor Ajay Rane had recently been awarded Honorary Fellowship of ICOG, the first Australian to receive this award, in recognition of his work in urogynaecology in Chennai, India, over many years. Professor Rane was congratulated on receiving this award.

### Report from the President

The President presented his report, including the following major items for information of Council:

- College response to the tsunami disaster in the South Pacific.
- Major events and items of interest for RANZCOG arising from the FIGO meeting in Cape Town, South Africa, October 2009. Dr Kenneth Clark is the retiring RANZCOG representative on the FIGO Executive Board and Dr Chris Tippet has been appointed in this role for the ensuing three-year period.
- Council governance review.
- Maternity services reviews in both Australia and New Zealand, and establishment of the Maternity Services Advisory Group (MSAG) to advise the Australian Government on issues arising from the Australian review.
- Establishment of the NHMRC Maternity Collaboration Project Reference Group (MCPRG) to develop an evidence-based guidance document for introduction of the proposed maternity changes. This document will be presented and discussed at an inter-professional forum to be held in Canberra, 10 December 2009.
- National Registration and Accreditation Scheme update.
- Review of RANZCOG trainee selection processes to ensure compliance with the Australian Medical Council (AMC) and the Australian Competition and Consumer Commission (ACCC).
- Review of the Strategic Plan of the Sixth RANZCOG Council confirms the work of Council is on track to achieve aims proposed in the plan.
- Review of education, assessment and training issues, with a view to development of working papers covering a range of training issues, for consideration in addressing workforce needs in the future.

### Report from the CEO

The Chief Executive Officer presented his report, including the following major items for information of Council:

- Health workforce planning in Australia through the National Health Workforce Taskforce.
- Review of risk management activities and preparation of up-to-date risk profile for the College.
- Major activities relating to education and training, as circulated in the report from the Director of Education and Training.
- FIGO Congress, Cape Town, South Africa, including a focus on initiatives surrounding the United Nations Millennium

Development Goal 5 (MDG 5) relating to improving maternal health globally.

- College interaction with the Australian Parliamentary Secretary for International Development Assistance, AusAID and the New Zealand Parliamentarians' Group on Population and Development (NZPPD), with a view to expanding links and partnerships to further the College's existing work in development assistance programs in neighbouring regions.
- College's Annual Accreditation report to the AMC and plans to undertake a systemic audit of accreditation standards in place in the College for major aspects of core business.
- AMC initiative and document, *Good Medical Practice: A Code of Conduct for Doctors in Australia*.
- Report on MedEd09 Conference, Sydney, October 2009, 'Investing in Our Medical Workforce'.

### Media and Public Relations Update

The Honorary Secretary advised that the Executive Committee is seeking to enlarge the College's profile in the media, branding and corporate image as seen by the community, government and outside bodies. The Executive Committee has shortlisted two companies to present their proposals at Executive's next meeting in New Zealand. The Executive Committee will continue to focus on forward planning in these negotiations and a document outlining these investigations will be presented to Council for approval prior to implementation.

### Education and Assessment

#### Acknowledgement – Professor Ian Pettigrew

The Education and Assessment Committee acknowledges with gratitude the outstanding contribution made by Professor Ian Pettigrew to the work of the committee since 1998, in particular, his work as an Examiner and Coordinator of the DRANZCOG Oral Examination.

#### Flexible Learning Program (FLP)

An Education Editorial Board will be established, led by an Editor-in-Chief, who will ensure that the development of FLPs and other online educative resources occurs in a timely manner and to a common standard. The Board will comprise lead editors for each FLP who would be supported by a writing group. Each writing group would consist of two to four Fellows and at least two senior registrars. The Chair advised that Associate Professor Stephen Robson has accepted the role of Editor-in-Chief, and on behalf of Council, the President thanked Associate Professor Robson for agreeing to take on this role.

#### Research Project

Options for alternative completion of the research project requirements continue to be considered. Assessment of completed research projects could in many circumstances become a prospectively-agreed in-house College procedure. Development of the research project support online modules continues. Two of these support modules should be ready to go online at the beginning of 2010.



Professor Bruce Dunphy has taken on the role of Coordinator of the Research Project Subcommittee and the committee is grateful for the contribution of Professor Gus Dekker in this role over the past three years.

### Training Accreditation Committee

#### New Regulation 16.1 Elevation to Fellowship

The following motion was carried.

#### THAT new Regulation 16.1 be adopted as follows:

'The FRANZCOG will be awarded to Trainees who have satisfied all training and assessment requirements for Fellowship as defined by the College, including having satisfactorily completed and been credited with 72 months of prospectively approved training.'

Current Regulations 16.1-16.3 to be deleted.

#### Amendment to associated Regulation 16.4 – applying for Fellowship (changes in bold). Reg 16.4 will now become Reg 16.2.

'It is the responsibility of the Trainee to contact the Training Services Department at College House to request an application for Fellowship. This can be done six months prior to completion of the stipulated 72 months of satisfactory training. However, application forms will only be prepared by College staff **when the Trainee has satisfied all training and assessment requirements for Fellowship as defined by the College. Trainees applying for Fellowship six months prior to completion of their 72 months must also meet these requirements, with the exception of the submission of their final six-monthly summative assessment report. This document must be submitted and assessed as satisfactory at the conclusion of the 72 months for Fellowship to be valid. [Delete: 'application forms will only be prepared by College staff once all Distance Education Program units, including the three mandatory post-Membership units, have been submitted and assessed as satisfactory. This regulation applies irrespective of the date when the request for an application is made.]**' The non-negotiable deadlines for requesting a Fellowship application form are 1 February (for March Council), 1 June (for July Council) and 1 October (for November Council). Signed and dated Fellowship application forms must be received at College House absolutely no later than 1 March (for March Council), 1 July (for July Council) and 1 November (for November Council).'

NOTE: Regulations 16.5 to 16.11 will be re-numbered, therefore, current Regulation 16.5 becomes 16.3 and so on.

#### New Regulation 3.2 MRANZCOG Requirements

The following motion was moved by Dr Sherwood and seconded by Professor Rane. The motion was put and carried.

#### THAT new Regulation 3.2 be adopted as follows:

'The MRANZCOG is awarded to persons who have met all training and assessment requirements for Membership as defined by the College, including having satisfactorily completed and been credited with 48 months of prospectively approved training.'

#### Amendments to associated Regulation 3.6 (in bold):

'It is the responsibility of the Trainee to contact the Training Services Department at College House to request an application for Membership. Application forms will only be prepared by College staff **when the Trainee has satisfied all training and assessment requirements for Membership as defined by the College. [Delete: '...once the Trainee has completed all requirements for Membership specified in regulations 3.1 to 3.5 above. This regulation applies irrespective of the date when the request for an application form is made.]**' The non-negotiable deadline dates for requesting a Membership application form are 1 February (for March Council), 1 June (for July Council) and 1 October (for November Council). Signed and dated application forms must be received at College House absolutely no later than 1 March (for March Council), 1 July (for July Council) and 1 November (for November Council).'

#### Amendments to Regulation 16.9 (previously 16.11) Completing Administrative Requirements for FRANZCOG

The following motion was put and carried.

#### THAT the following amendment to Regulation 16.9 be adopted:

'Elevation to Fellowship is not complete until all remaining administrative requirements for Fellowship have been met. This includes payment of elevation fees and submission of the following: logbooks; final six-monthly summative assessment reports (if not yet submitted); signed Certificate of Satisfactory Completion of Training; proof of current Medical Board registration; and proof of Australian or New Zealand residency (as applicable). Candidates must complete these requirements within six months of the Fellowship elevation date. If this requirement is not met by that time, the offer of Fellowship will lapse **permanently, unless exceptional circumstances apply.**'

#### Regulation 10.6 (Extended Leave from the Program) and Regulation 12.1 (Removal from the Program)

The following motion was moved by Dr Sherwood and seconded by Dr Pecoraro. The motion was put and carried.

#### THAT the following amendments to Regulation 10.6 and Regulation 12.1 be adopted:

- 10.6 'Trainees may take a maximum of two years' cumulative leave from the training program (therefore, in excess of the standard yearly leave entitlement of eight weeks, which includes annual leave, parental leave, extended sick leave, research leave or leave without pay). However, this cumulative leave is subject to the written approval of the relevant Regional/New Zealand Training Accreditation Committee Chair. Trainees can only exceed the permitted two years of cumulative leave if they obtain prospective written authorisation from the relevant Regional/New Zealand Training Accreditation Committee Chair. Trainees who exceed the permitted maximum of two years' cumulative leave without such authorisation will be removed from the training program (see Regulation 12.1).'

### **Amendment to associated Regulation 12.1 (changes in bold):**

'Unless the College Training Accreditation Committee accepts that exceptional circumstances exist, a Trainee will be removed from the training program if:

- The ITP is not completed within eight years of the date of the commencement in the program; or
- The requirements for Fellowship are not met within 11 years of the date of the commencement in the program; or
- Either the MRANZCOG Written or Oral Examination is not passed within the maximum four attempts; or
- The relevant Regional/New Zealand Training Accreditation Committee/Committees assess three six-monthly reports as Fail during the course of the MRANZCOG/FranzCOG training program; or
- The Trainee fails on a second occasion in the course of the training program to submit a three-monthly formative assessment report and/or a six-monthly summative assessment report/clinical training summary to the Executive Officer at the relevant Regional Office within 12 weeks of the end of the relevant training period; or
- **The Trainee has exceeded the permitted maximum of two years' cumulative leave from the program without prospective written authorisation from the Chair of the relevant Regional/New Zealand Training Accreditation Committee Chair.'**

### **New subsection 10.1 – to be called 'Registration/Annual Fee Payment/Obtaining Prospective Approval of Training' (to replace the current Subsections 10.1 – 10.3)**

The following motion was moved by Dr Sherwood and seconded by Dr Kesby. The motion was put and carried.

#### **THAT the following new subsection 10.1 be adopted:**

- 10.1.1 Trainees must submit their RANZCOG registration form to the relevant Regional Office and pay their training fee to the Finance Department at College House by 31 January each year. A registration form must be submitted even if the Trainee is not intending to train in the relevant year. If such Trainees wish to stay on the Register while taking leave from the training program, they are required to pay 50 per cent of the annual training fee. If the Trainee has decided to withdraw from the program entirely, a registration form is not required, but written notification of withdrawal must be provided to the Training Services Department.
- 10.1.2 Trainees who do not submit a registration form and/or pay the annual training fee by 31 January of each year will be regarded by the College as unregistered and/or unfinancial. Training undertaken while trainees are unregistered and/or unfinancial will not be credited by the College, even if prospective approval of training has been obtained (see Regulation 10.1.3). Trainees who have not registered and/or paid the training fee by 31 January of each year will also incur a late fee (calculated as ten per cent of the annual training fee) for each month they are overdue. Trainees who are unregistered and/or unfinancial will not be permitted to sit the MRANZCOG Written and/or Oral Examination (as applicable).

- 10.1.3 All ITP/Elective training must be prospectively approved in every year of training. To do this, trainees must complete and submit to the relevant Regional Office the RANZCOG application for prospective approval of training, which must be checked and signed (if approved) by the relevant Regional/New Zealand Training Accreditation Committee Chair. This application must be submitted not less than four weeks prior to the commencement of training. Only training which has been prospectively approved by the relevant Training Accreditation Committee Chair (therefore, checked and signed off) will be credited by the College. Any training undertaken prior to obtaining this approval for the relevant year will not be credited. In the event that a Trainee submits an application for prospective approval after commencing a block of six months' training, the training already completed in that period will not be credited, therefore, in accordance with College regulations that all training must be in blocks of at least six months (see Regulation 10.4.3).

NOTE: Current Regulation 10.1.4 will remain unchanged and will remain part of the new subsection 10.1 above. The existing regulations 10.2 and 10.3 will be removed.

#### **ITP Hospital Re-accreditation**

Thirty sites have been re-accredited so far in 2009, while seven hospitals underwent a follow-up visit due to concerns about their performance as training units. Twelve of the College's 90 accredited hospitals remain to be visited. The first re-accreditation cycle will therefore be completed by the end of 2010, including those sites which require follow-up visits within 12 to 24 months of the initial re-accreditation visit.

### **Indigenous Women's Health Committee**

#### **RANZCOG 2011 Indigenous Women's Health Meeting, Cairns, Queensland**

Following the success of the RANZCOG 2008 Australian Indigenous Women's Health Meeting held in Darwin, the Indigenous Women's Health Committee is intending to hold another meeting in Cairns in 2011. The Cairns Convention Centre is being investigated as the venue for the meeting, which will likely be held in May/June 2011. The ASM Secretariat will be involved in organising the meeting.

### **Fellowship Review Committee**

#### **Verification Check Report**

There are 913 Fellows due for completion of their CPD requirements during 2009; 46 (four subspecialists) of these have been randomly selected for a Verification Check. Seven of these were selected in 2003, two were selected in 2006 and one was selected in 2003 and 2006.

- One Fellow who was selected in 2003, 2006 and 2009 has been granted an exemption by the CPD Committee from the 2009 Verification Check.
- 27 Fellows have successfully completed the Verification Check.
- Three Fellows have been advised of their selection.
- Two of these Fellows have provided documentation.
- One Fellow has retired.
- One Fellow has been granted a three-month extension to his current CPD period.

### Defaulting Fellows

Currently there are eight Fellows on the overdue list and concern was expressed that the majority of overdue Fellows had zero points which indicates that they are not submitting their annual points claim (APC) forms on an annual basis. A memorandum from the CPD Chair encouraging Fellows to submit their APC forms is currently sent to all Fellows. The content of this memorandum will be reviewed by the CPD Chair. It was also noted that the new regulations for National Registration due for implementation from 1 July 2010 may require evidence of points rather than participation and annual submission of an APC would provide this information.

### Asia Pacific Committee

#### 10.18.2 RANZCOG Volunteers Register

Over 100 Fellows have enrolled on the Volunteers Register, indicating interest in working in developing countries or responding to requests for teaching, locum assistance, etc. Six new volunteers have taken up postings this year from email advertisements to the Volunteers Register, providing teaching visits to the University of Papua New Guinea and the Fiji School of Medicine. A mechanism to obtain and evaluate feedback from visits is under discussion.

#### 10.18.3 Visit to RANZCOG by Dean, Fiji School of Medicine

Professor Ian Rouse, Dean of the Fiji School of Medicine (FSM), has been invited to the March face-to-face meeting of the Asia Pacific Committee to discuss ways that RANZCOG can support FSM and what educational support they seek from RANZCOG.

### Provincial Fellows

#### Review of RRMA Classifications

The Commonwealth Government has reviewed the Rural, Remote, Metropolitan Area (RRMA) classifications, which will be replaced in 2010 with a new system called the Australian Standard Geographical Classification – Remoteness Area (ASGC-RA). It is envisaged that ASGC-RA will be implemented for all programs governed by this classification by 1 July 2010.

### Specialist Obstetrician Locum Scheme

The Specialist Obstetrician Locum Scheme (SOLS) has signed a A\$3 million funding agreement to continue the program to 30 June 2011. Changes to the new funding agreement include an increase in the number of locum placements and daily subsidy for both specialists and GP obstetricians. Handover time is no longer paid and unsubsidised locum support is no longer capped.

## REQUESTS FOR EXTENSION TO CONTINUING PROFESSIONAL DEVELOPMENT (CPD) PERIOD

### Extension requests – six months and greater

Have you been absent from medical practice for a period greater than six months due to maternity leave, ill health or other exceptional circumstances?

If so, why not apply for an extension to your current Continuing Professional Development (CPD) period?

#### APPLICATION

Requests for extensions can be made in writing to the Chairman of the Continuing Professional Development Committee (CPDC). Proof of maternity leave, ill health or exceptional circumstances must be supplied.

#### PROCESS

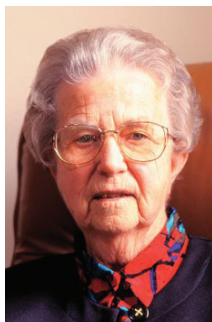
The Chairman of the CPDC will consider requests for extension of six to 12 months. Requests greater than 12 months will be considered by the full CPDC, which meets three times a year (March, July and November).

If you are absent from practice for a period greater than two years, please see the re-entry policy following a prolonged absence from practice at: [www.ranzcog.edu.au/publications/statements/wpi13.pdf](http://www.ranzcog.edu.au/publications/statements/wpi13.pdf).

For further queries contact:

Val Spark  
CPD Senior Coordinator  
Ph: +61 3 9412 2921  
Fax: +61 3 9419 7817  
E-mail: [vspark@ranzcog.edu.au](mailto:vspark@ranzcog.edu.au)

# Obituaries



**Dr Helen Pearl Mackenzie**  
1913 – 2009

Helen was born in Pusan, South Korea, the eldest of five children of missionary parents. She was educated at the American Missionary School in Pyongyang, but completed her schooling at Presbyterian Ladies' College, Melbourne. Along with her sister, Catherine, she planned to return to Korea as a medical missionary and studied medicine at the University of Melbourne, graduating in 1938. The Second World

War prevented them from returning to Korea, but she gained invaluable experience in surgery at Bendigo Base Hospital and in O and G at Queen Victoria Hospital, Melbourne, finishing her time there as Acting Medical Superintendent.

In 1945, Helen and Cath accepted a call from the Church of Christ in China and established a small hospital in an old Taoist temple in Jianshui, Yunnan, the only 'western medicine' within three days journey. They had to leave in 1950 after the communist takeover but the hospital continued and is now the provincial hospital.

Eventually, in February 1952 at the end of the Korean War, they returned to Korea. The medical needs were overwhelming but they were advised that the main medical need was in maternal and child health. On 17 September 1952, Il Sin Women's Hospital was opened in a kindergarten hall, with 20 beds and a staff of five. A major objective was to train women doctors in obstetrics and gynaecology and nurses in midwifery. At that time, it was difficult for female graduates to get good training and with changes in nursing education, nurses were being given midwifery certificates along with

their basic certificate, sometimes not even having seen a normal delivery. The hospital became highly regarded throughout Korea for training and expert care.

Helen was a brilliant surgeon and, although often tired with the constant load, would spend hours in the operating room or delivery room for just one patient. She was also a great educator, but said it was easy to teach as almost all O and G abnormalities were seen. When Helen retired in 1976, twelve doctors had been trained in O and G and since then a further 120 (all women) have graduated. To September 2009, 2599 nurses have graduated as nurse midwives and 284,655 women delivered of their babies.

On retirement, Helen studied theology, including Hebrew, at the University of Melbourne and wrote a biography of her father titled *Mackenzie, man of mission*. She continued her love of music and learned to play the pipe organ.

Helen received many awards from the Korean Government and in 1962, along with Cath, she was awarded the Member of the Order of the British Empire (MBE). Helen had not had the opportunity for specialist training, but in October 2002, she was awarded an Honorary FRANZCOG in recognition not only of her expertise in this field, but also of all that she did for training women in the specialty.

Helen died on 18 September 2009 and is survived by her sisters Lucy Lane and Sheila Krysz and their families.

**Dr Barbara Martin**  
FRANZCOG  
Melbourne, Victoria

**Dr Beryl Collier**  
1928 – 2009

Beryl Collier was born on 31 March 1928 in Mosman, New South Wales. She was educated at North Sydney Girls' High School. She studied medicine at the University of Sydney graduating MBBS in 1952. Over the next ten years, Beryl held RMO/SHO and registrar appointments at numerous hospitals including Kurri Kurri, New South Wales; Bundaberg, Queensland; Queen Victoria Hospital, Adelaide; and York, United Kingdom.

In 1963, Beryl was appointed Medical Administrator at Ba Mission Hospital in Fiji. She spent the following year at the Royal Cornwall Infirmary in Truro, United Kingdom.

In 1966, Beryl was lecturing at the Papuan Medical College in Port Moresby, Papua New Guinea, when Dr Stanley Devenish Meares, President of the Australian Council of the Royal College of Obstetricians and Gynaecologists, visited. Recognising Beryl's ability and enthusiasm, he suggested she could make a valuable contribution to the specialty of obstetrics and gynaecology. Beryl subsequently gained her MRCOG in 1969 and entered private practice in Wagga Wagga, New South Wales, with a HMO appointment at the Base Hospital. She became a Foundation Fellow of RACOG in 1979 and was elevated to Fellowship of the RCOG in 1982. Beryl donated items to the RANZCOG Historical Collections.

Beryl eventually settled in Gosford, New South Wales, and commenced private practice with a HMO (later VMO) appointment as gynaecologist/obstetrician at Gosford Hospital from 1972, where she worked until her retirement in 1988. She was named a 'Significant Woman of the Central Coast' for 2004 and 2005 in recognition of her work in the Central Coast Reconciliation Group.

Beryl passed away on 1 August 2009 after a long period of ill health.

Beryl's competence, commitment and empathy with her patients made her very welcome in Gosford, particularly as she was the first and only female gynaecologist on the Central Coast of New South Wales throughout the years during which she lived and practised in the region.

**Dr David Charles Morton**  
FRANZCOG  
New South Wales





### **Dr Colin Douglas-Smith**

1918 – 2009

Colin was known in rowing circles as 'C D Smith' and changed his name by hyphenating his middle name. He was successful in rowing at school, university and in the King's Cup, and represented Australia in the London Olympics of 1948. He carried the Olympic torch before the Sydney Olympics in 2000.

Colin was born on 11 July 1918 and grew up in Geelong on the shores of Corio Bay, Victoria. He was educated at Geelong Grammar School where he was influenced by the progressive headmaster Sir James Darling.

He began studying zoology at the University of Melbourne in 1938, but later changed to medicine. He was released to join the Royal Australian Navy in 1940 and was seconded to the Royal Navy to fulfil an ambition to serve in submarines, where he rose to First Lieutenant. On demobilisation, he resumed his medical studies in 1946 and married Kathleen Aberdeen, the daughter of a doctor.

Upon graduation in 1949, he undertook residencies at the Alfred Hospital and Melbourne Women's Hospital and in 1955 at the Gloucester Infirmary in the UK, where he achieved the MRCOG.

Upon his return, he settled in Western Australia, joining the practice of Hugh Callagher and John Lindsay Taylor and was appointed to the Honorary Staff of King Edward Memorial Hospital (KEMH). He developed a busy practice, becoming a senior O and G with his own unit at KEMH, where he served on the board for many years and eventually became Chair. He was noted for his patient and kindly teaching. He was Chair of the 1975 Australian Congress in Perth and also served on the Australian Medical Association. He was elevated to FRCOG in 1970 and became a Founding Fellow of the FRANCOG in 1979. For 25 years, he and Andrew Kingsbury provided an extensive O and G visiting service to the isolated Pilbara towns of Tom Price and Paraburdoo, Western Australia.

Colin was actively involved in the Yoga Association of Western Australia, writing a handbook on yoga in pregnancy.

A great family man, he passed on his message of diet and exercise to his children and grandchildren. In his final years, he received a setback from complications from surgery, but maintained an active interest in his family and friends until his death on 20 October 2009. He is survived by his wife Kathy, four children and his many grandchildren and great grandchildren.

### **Dr Andrew Kingsbury**

FRANZCOG

Western Australia

### **Dr Paul Ellis Jeffery**

1918 – 2009

Paul was born on 8 November 1918. He was known by many of his colleagues as the last of the masterful 'intrauterine manipulators' – an art that has died out with changes in obstetric practice. Because of the financial straits of the 1930s Depression, he left school prematurely at 14 years of age. However, he managed to obtain work, paying for and completing his schooling. He subsequently attended the University of Melbourne, where again he supported himself working as a proof reader for *The Argus*, a Melbourne newspaper. Paul graduated MBBS with honours in medicine in 1945.

From 1945 to 1947, Paul served as a junior RMO and subsequently senior RMO at St Vincent's Hospital, Melbourne. For the next two years he was in general practice at Preston and during 1949 served as a ship's surgeon with the Blue Funnel Line.

In September 1949, he started as junior RMO at the Royal Women's Hospital (RWH), Melbourne, following as Registrar from 1950 to 1951. From 1951 to 1953, he was the senior Registrar, a post subsequently abolished after the introduction of the individual 'unit' system in which obstetrics and gynaecology functioned as independent departments.

Paul obtained the Diploma of Gynaecology and Obstetrics (DGO) in Melbourne in 1952. In 1953, he travelled to the UK where he gained further experience at various hospitals and completed his MRCOG in 1954, returning to Australia in August 1955.

From 1955, he held the position of Honorary Associate Surgeon at RWH working in Dr Ronald Rome's obstetric unit, where he honed his great skills in obstetrical 'intrauterine manipulation'. From 1959 to 1970, he was Honorary Outpatient Surgeon in Dr Noel de Garis' obstetric unit. In 1970, he was elevated to Inpatient Surgeon of the obstetric unit and was also in charge of the specialist diabetic unit until 1978. During his tenure, fetal mortality amongst diabetics declined significantly.

Paul was elevated to Fellowship of the RCOG in 1970 and became a Foundation Fellow of the RACOG in 1979.

Paul was chair of the RWH Obstetric Staff from 1971 to 1973. He retired from active RWH duties in 1978 and subsequently was appointed as an Honorary Consulting Surgeon. He remained in private practice for many years following hospital retirement.

Paul Jeffery died at the age of 90 on 21 April 2009.

### **Mr William Chanen**

FRANZCOG

Melbourne, Victoria

**Dr Harold Roberts-Thomson**

1919 – 2009

Harold, 'Hag' to his colleagues, was born on 10 January 1919 on the north-west coast of Tasmania, one of ten children. He was educated first at Wynyard and completed his secondary education at The Hutchins School, Hobart. After first year science at the University of Tasmania, he transferred to Melbourne, graduating MBBS with honours in 1942.

After a six-month residency at the Royal Melbourne Hospital, he joined the Royal Australian Airforce, serving from 1943 to 1946 in the South West Pacific, firstly as Medical Officer to the Radar Wing and later as Medical Officer to 80 Squadron in Borneo.

Demobbed in 1946, Hag trained at the Royal Women's Hospital (RWH) in Melbourne. He gained his Diploma in Gynaecology and Obstetrics in Melbourne in 1949 followed by MRCOG in 1950 (FRCOG 1966). In 1975, he was elected a Fellow of the Royal Australasian College of Surgeons for services to medical teaching. He was a Foundation Fellow of the RACOG in 1979. He was a member of the Australian Regional Council of the RCOG from 1959 to 1965.

Harold commenced private O and G practice in Launceston, Tasmania, in 1950. He was honorary gynaecologist to the Launceston General Hospital, honorary obstetrician to Queen Victoria Hospital (QVH), lecturer in the midwifery school, and clinical supervisor for medical students at QVH. He served on the Board of Management of QVH and as Chair of the Medical Advisory Committee.

In the early 1970s, despite a large private practice, Harold spent time at the RWH Melbourne in the radio-surgical unit training in gynaecological cancer surgery, alternating with Lachlan Hardy-Wilson in time away from Launceston. With this experience, they were able to offer effective gynaecology cancer management in Launceston. He continued in private practice following compulsory retirement from his public hospital appointments, until 75 years of age.

Harold had a great talent for all ball games and when time permitted demonstrated this gift. He was Tasmanian table tennis champion at 18; University Blues in tennis and football; runner-up in the 1959 Australian doubles hard court championship, and in 1981 represented Australia in the world billiards title. A natural golfer, he played off a handicap as low as three. With advancing years, Hag turned to lawn bowls and became an A-grade player. Still later, he became an Australian Master in contract bridge.

Harold died on 22 March 2009, shortly after his 90th birthday. He is survived by his wife Helen, children Penny, Anne, Philip, and their families, and the family of his son Bruce, who died after a car accident in 1996. Hag will be remembered as a quiet, self-effacing doctor who was respected and loved by his patients, friends and colleagues.

**Dr John Grove**FRANZCOG  
Tasmania**Dr Noel Brougham Docker**

1942 – 2009

Noel was born on 31 August 1942 at Coonabarabran in New South Wales. He came from three generations of New South Wales country medical practitioners and held that old school country doctors' view that medical practice was a 24-hours-a-day seven-days-a-week commitment. In 1967, Noel graduated in medicine from the University of Sydney where he was Senior Student of St Andrew's College. He trained at the Mater, North Sydney, and St Margaret's, Darlinghurst, and then in the UK, obtaining his MRCOG in 1973.

On his return to New South Wales, Noel single-handedly provided consultant services to Goulburn and district from 1974 to 1993. He was a Foundation Fellow of the RACOG, being elevated to Fellowship of the RCOG in 1991. Noel was one of the 50 RACOG 'guinea pigs' who trialed the American College CME Précis Program questions in the early days of our College. In spite of being one of the busiest obstetricians in the country, he was still one of the first to complete the very time-consuming task!

In 1993, Noel moved to Newcastle where he had appointments at public and private hospitals from central Newcastle to Wyong. He held office on several occasions as Chair of the Lake Macquarie Private Hospital Staff Council, was a member of the Executive and Treasurer of the Newcastle O and G Society (NOGS) for ten years, and was a constant source of new and innovative ideas over that period, in spite of having a very heavy work load.

In his limited spare time, Noel indulged his love of music and read the classics and history. Noel married Clare in 1967 and was blessed with four children and nine grandchildren.

Noel died on 4 August 2009 at Newcastle. His unexpected death saddened the whole community of Newcastle. We shall all miss him and wish to express to his family our deepest sympathy.

**Dr Alan D Hewson**FRANZCOG  
Merewether, New South Wales**Notice of Deceased Fellows**

The College was saddened to learn of the death of the following:

Dr Antony **Baccarini**, NSW, on 5 February 2010  
 Dr Michael **Bowen**, UK, on 3 September 2009  
 Dr Norman **Crooke**, WA, on 31 January 2010  
 Dr Colin **Douglas-Smith**, WA, on 20 October 2009\*  
 Dr Michael **Kloss**, Vic, on 15 November 2009  
 Dr Jean **Murray-Jones**, WA, on 27 December 2009  
 Dr Joan **Storey**, NSW, on 6 November 2009

\* Obituary published in this edition of *O&G Magazine*.

# RANZCOG Women's Health Award 2009

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists is proud to present the RANZCOG Women's Health Award for the fifth consecutive year, to outstanding university students in obstetrics and gynaecology from medical schools across Australia, New Zealand, Papua New Guinea and Fiji.

The College is dedicated to promoting the specialty of obstetrics and gynaecology as an exciting and worthwhile career option and anticipates that this award will help foster awareness of the specialty amongst medical students.

At the time of going to press, the RANZCOG Women's Health Award 2009, valued at A\$500, was received by the following successful awardees:

**Kate Manos**

School of Paediatrics and Reproductive Health,  
University of Adelaide

**Anna Dare**

University of Auckland

**Katie Hobbs**

Faculty of Health Sciences, Flinders University

**Susan Hawes**

Griffith University

**Hannah Bourke, Jun Parker, Jessica Weekes**

School of Medicine, James Cook University

**Lai Yin Law**

School of Medicine, University of Melbourne

**Amy Rebecca Jamieson**

School of Medicine, Dunedin Medical School,  
University of Otago (see photo on right)

**Jodie Ross**

University of Queensland

**Timothy Sullivan**

University of Sydney

# Australian & New Zealand Honours Awards

**The following RANZCOG Fellows and members recently received Australian and New Zealand Honours awards:**

**New Zealand New Year Honours 2010**

**Dr Peter Richard Fisher (CNZM)**

Awarded the Companion of the New Zealand Order of Merit.  
For services to medicine.

**Dr Frederick Malcolm Graham (CNZM)**

Awarded the Companion of the New Zealand Order of Merit.  
For services to medicine.

**Australia Day Honours 2010**

**Dr Terence Joseph Horgan (OAM)**

Awarded the Medal in the General Division of the Order of Australia.

For service to the community as a fundraiser for Catholic charitable organisations.



*RANZCOG Fellow, Dr Rosemary Reid, presents the RANZCOG Women's Health Award 2009 to Amy Rebecca Jamieson from the University of Otago, New Zealand.*

# RANZCOG GIFTSHOP

# SALE!!



**UP TO 50% OFF ALL ITEMS FOR A LIMITED TIME ONLY. SALE ENDS 31/05/10**  
ALL PRICES ARE GIVEN IN AUSTRALIAN DOLLARS AND INCLUDE GST.

**Umbrellas**—navy blue with College crest in gold:

- **Small folding umbrella** with wooden handle. Was \$24.20 **NOW \$12.50**
- **Large golf umbrella**, clear lacquered wood handle. Was \$33 **NOW \$16.50**
- **Long umbrella**, clear lacquered wood crook handle. Was \$27.50 **NOW \$14.00**



## Ties

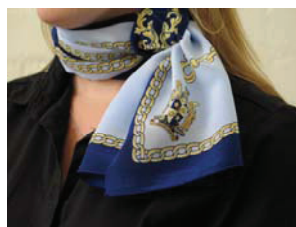
**Bow tie**—100% pure woven silk, featuring the College shield, available in tie-your-own OR ready-tied. Was \$60.50 **NOW \$30**

**Striped tie**—blue and gold, 100% pure woven silk and featuring the College shield. Was \$60.50 **NOW \$30**

**Navy tie**—100% woven silk, fine blue & gold diagonals and a single College crest. Was \$60.50 **NOW \$30**

**Rugby tops**—navy blue with embroidered College crest (65% polyester / 35% cotton). Available in XXL only. Was \$90 **NOW \$45**

**Polo tops**—navy blue pure cotton pique with embroidered College crest. Available in S, M, L, XL or XXL. (Limited stock) Was \$90 **NOW \$45**



## Scarves

**Oblong** (130 x 42 cm) scarf—100% pure silk crêpe de chine. Pale blue, gold chain motif and College crest. Was \$60.50 **NOW \$30**

**Square** (88 x 88cm) scarf—100% pure silk crêpe de chine. Navy border and gold leaf motif on pale blue ground. Was \$66 **NOW \$30**

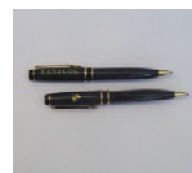
**Golf balls**—Bridgestone B330 Tour with College shield. For serious players or professionals. Set of three was \$30 **NOW \$15**



**Coasters**—silver, embossed with College crest. Set of six was \$30 **NOW \$15**



**Pens**—All metal blue pens. Laser engraved with College crest and name. Twist action. Parker type with ink refill. Was \$36.60 **NOW \$15**



ORDER FORM ON THE BACK





*Membership of the RANZCOG Research Foundation is open to all members of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) and to all others with an interest in the aims and objectives of the Foundation.*



**RANZCOG  
Research Foundation**

Medical research in Australia and New Zealand is internationally recognised for its excellence. By joining the RANZCOG Research Foundation, you are directly contributing to this research and in particular, to the future of women's health.

The Foundation also welcomes donations. Both membership fees and donations are tax deductible.

## **Application for Membership and Donation to the RANZCOG Research Foundation**

Name: \_\_\_\_\_

Postal Address: \_\_\_\_\_

**Annual Subscription:** 1 July 2009 - 30 June 2010

- |  |             |                  |
|--|-------------|------------------|
| <input type="checkbox"/> Fellows in Australia              | \$AUD110.00 | Includes 10% GST |
| <input type="checkbox"/> Fellows overseas                  | \$AUD100.00 |                  |
| <input type="checkbox"/> Others (non-Fellows) in Australia | \$AUD55.00  | Includes 10% GST |
| <input type="checkbox"/> Others (non-Fellows) overseas     | \$AUD50.00  |                  |

### **Donation to the RANZCOG Research Foundation**

\$50     \$100     \$500     \$1,000     Other \_\_\_\_\_

*The Foundation is proud to accept and acknowledge donations.*

*I give the RANZCOG Research Foundation permission to publish my name as a donor to the Foundation in any College publications.*

Yes

No

**Total amount payable:** \$AUD \_\_\_\_\_

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If paying by cheque, please make cheques payable to:

'The Royal Australian and New Zealand College of Obstetricians and Gynaecologists' or 'RANZCOG'

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**Helping to drive research excellence in women's health**

RANZCOG Research Foundation (ABN 23 004 303 744)

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