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Death

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists

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Death

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Message from the President

Dr Ted Weaver
President

When I started to think about writing this column, the news had just come out about the Victorian bushfires and their grim and dreadful aftermath, with so many lives and property lost. It seems inconceivable that so many lives could be lost so quickly, and on behalf of the College, I would like to extend our deepest sympathy to those associated with the College in any way who may have lost loved ones. When news of the tragedy broke, the College contacted the Victorian Health Department, to enquire if there was anything we, as a College, could do to help the relief effort. We were reassured that there were systems in place and that the best thing we could do was to make a monetary donation. With the general support of College Council, this was duly done. I would also like to pay tribute to the College House staff, who organised a monetary donation as well as donations of essential items to the victims.

With all of this going on, it is salutary to reflect on the really important things in life. It is almost presciently ironic that this issue of *O&G* focuses on 'death'. Rarely are we as a specialist group involved in disaster management, but it is sobering to reflect that, even in a discipline like obstetrics, where we often share in parents' unbounded joys, perinatal and, more rarely, maternal death are ever present threats, and that gynaecological surgery, no matter how minor, can still pose a risk to a woman's life.
We are fortunate to live in countries like Australia and New Zealand that have well-developed maternity care systems, but as the recently commissioned Maternity Services Review illustrates, that is not to say those systems cannot be improved. Professor Glen Mola's article in this edition provides an insight into maternal mortality and morbidity problems in the developing world, highlighting problems that may be partially mitigated through efforts of College Fellows. I would encourage you to read it.

The National Registration and Accreditation Scheme (NRAS) which was proposed by the Committee of Australian Governments (COAG) was mentioned by the then RANZCOG President, Dr Christine Tippett, in *O&G* Vol 10 No 2 Winter 2008. Since then, the enabling legislation for the scheme (*Bill A*), has been passed by the Queensland parliament, and further enabling legislation, *Bill B*, is undergoing drafting. The College, through the Committee of Presidents of Medical Colleges (CPMC), has provided in principle, support to a National Registration Scheme, but has opposed a National Accreditation Scheme, where the power to accredit doctors is ceded to a Ministerial body. This arrangement has the potential to cause an erosion in clinical standards and patient safety, and undermines the position of the Australian Medical Council and the colleges, who provide training and maintenance of standards in the specialist workforce. Through CPMC, the College has mounted vigorous opposition to this scheme and has also put in a submission to the Government outlining our concerns. These proposed reforms are a serious threat to our profession. I can assure you that the College will vigorously oppose them and will aim to confirm our position as a standards and training body. I would urge you to be conversant with the proposed reforms, and to lobby your local member of parliament and state health minister about the need to separate the processes of specialist registration and accreditation. The latter process informs the former, but should be conducted by an independent body.

There are other parts of the NRAS document which relate to having a specialist register separate from the general medical register, and provisions relating to Area of Need practitioners. Both the CPMC and the College are extremely concerned about these proposals and they are opposed in our response document.

The report from the Maternity Services Review was released on 21 February 2009 at Sunshine Hospital, Melbourne, by the Federal Health Minister, the Hon Nicola Roxon MP. Prior to the report's release, Dr Tippett and I had a meeting with the Health Minister in January, at which time we discussed various concerns that RANZCOG has with the current provision of obstetric and gynaecological services in Australia. These concerns included the ageing obstetric workforce; the maternity care of disadvantaged and migrant women; problems with postnatal care and poor breastfeeding rates; and the need for team-based maternity care. We highlighted our opposition to 'independent' midwifery practice. The Minister was eager to meet with RANZCOG again once the Maternity Services Review report was released, for further discussions.

'The Maternity Services Review report has a strong focus on safety and quality and again highlighted that Australia is a safe place to give birth or be born.'

The Maternity Services Review report has a strong focus on safety and quality and again highlighted that Australia is a safe place to give birth or be born. The report makes 18 key recommendations, including, among other things, the need for a national perinatal and maternal morbidity and mortality data set; the need for targeted research about obstetric interventions; the need for the development of multi-disciplinary practice guidelines; various improvements in the care of Indigenous, remote and rural women, and postnatal services; changes in arrangements in access to the Pharmaceutical Benefits Scheme (PBS) and Medicare Benefits Schedule (MBS) that would allow an increased role for midwives within collaborative team-based models; and the need to investigate the possibility of funded midwife indemnity insurance.

The Review did not support 'independent' midwifery practice, nor funding of home birth. The College had vigorously opposed both of these practices in its submission to the Review. The next step will be the development of a National Maternity Services Plan. The College looks forward to close involvement with the Government and others in that process.

As it is likely that the Maternity Services Review outcomes will change the way that maternity care is provided in Australia, it is important that we have continuing dialogue with our midwifery colleagues. We had a meeting with the Australian College of Midwives in late February, in what I hope will become a regular dialogue. There were a number of items for discussion, including the Maternity Services Review; the possibility of developing co-badged referral guidelines for midwives in practice; and the possibility of midwives becoming educational affiliates of the College.

There has been a lot of activity at Committee level over the past few months focusing on training, education and assessment. The curriculum for Fellowship Training is currently being reviewed and as an extension of that, there has been discussion about the possibility of revamping the Integrated Training Program and advanced training requirements. In 2008, during Council week in July, there was a Council forum about the system of modular training in the advanced years of the RCOG Training Program. Council is concerned that we need to look critically at the outcomes of our training scheme. A number of questions have been posed. Can we still train everyone to do everything? Is there a need to split the speciality of obstetrics and gynaecology? Should we have surgical and medical streams within the specialty? Should we have categories of Fellowship? Should we allow subspecialty training to occur much sooner than we currently allow?

'We are fortunate to live in countries like Australia and New Zealand that have well-developed maternity care systems, but as the recently commissioned Maternity Services Review illustrates, that is not to say those systems cannot be improved.'

To answer these questions, the forum during March 2009 Council week will be devoted to education and assessment. We will be discussing different ways to revamp the training system to provide the specialist workforce that Australia and New Zealand will need. In addition to RANZCOG Councillors who have taken the responsibility to lead the discussions, the current RCOG President, Professor Sabaratnam Arulkumaran, will be in attendance and will contribute from the perspective of recent developments in this area in the United Kingdom.

The joint AOFOG 2009/RANZCOG 2009 Annual Scientific Meeting will be held in Auckland, New Zealand, from 26 to 30 March. I would like to congratulate Professor Peter Stone, head of the Scientific Committee, for the wonderful job he has done in organising the program. Keynote speakers include Professor Christopher Lynch, Mr Tim Child and Professor Siladitya Bhattacharya, who are all eminent experts in their fields. The AOFOG and RANZCOG programs have been blended. The AOFOG program certainly brings a different emphasis and adds breadth to our Annual Scientific Meeting program. There is also a great social program to go with the academic program and I would encourage you to attend and support your College's ASM.

Practice visits were introduced as a Continuing Professional Development activity by the College several years ago. They were introduced initially in New Zealand and championed by Dr Mark Insull. They have proven to be very successful there with over 80 per cent of New Zealand Fellows visited. They have been so successful that the New Zealand Medical Council is looking at using our Practice Visit template as part of reaccreditation of medical practice. For a number of reasons, Practice Visits have never flourished in Australia as they have in New Zealand. The College is looking at ways of progressing Practice Visits as a relevant and valued Continuing Professional Development activity for Fellows in Australia.

Last year, the Western Australia Regional Committee hosted a meeting to honour the life and work of Dr Tony McCartney, on his retirement from public practice. A well-attended clinical meeting was held in Perth in March 2008. The profits from that meeting have been put into a scholarship and I am happy to inform you that this scholarship was approved by the College Executive Committee at their February meeting. The scholarship will be awarded to a trainee specialist or subspecialist, enabling them to access continuing education in the areas of advanced laparoscopic surgery or gynaecological oncology. This is a great thing for the College and I would like to thank the Western Australia Regional Committee and Dr McCartney for their generosity.

This column gives a snapshot of some of the things happening in the College. Life there is busy, and the College is only as strong as the sum of its parts. I would encourage you to support your College and hope to see a lot of you in Auckland in March.

Message from the CEO

Dr Peter White
Chief Executive Officer

I am not the only person in this edition of *O&G* Magazine to reflect on the tragic irony of the theme of the issue when one considers the timing of its compilation and the recent, unprecedented bushfire events in Victoria that left a trail of devastation in their wake. That the flood crises in Queensland and New South Wales could be overshadowed is testament to the scale of the events. Enormous amounts of media comment have been made, the extent of coverage such that I have received contact from individuals in the United Kingdom and the United States expressing astonishment at the scale of the events and sympathy for those affected. A response from the College that would be of tangible benefit was appropriate at the time and I thank all involved in enabling that response to occur in an informed and timely manner befitting the circumstances.

As individuals involved in the delivery of healthcare and allied services, readers of this publication are familiar with the events surrounding death. An inevitable consequence of life and its associated morbidities and degenerations, its onset can take numerous guises; anticipated and sudden, preventable and inevitable, swift and slow. For the same readership, however, there is frequently the opportunity to share in the experiences at the opposite end of the life continuum, in some cases bringing about the preconditions and initiating the processes associated with its very conception.

There are, of course, many among the readership who experienced the conception and birth of RANZCOG as an organisation in the late 1990s. Some will also have clear recollections of the life and times of the parent bodies on both sides of the Tasman; the Royal Australian and the Royal New Zealand Colleges (RACOG and RNZCOG). The offspring reached a milestone late last year, celebrating its tenth birthday in a relatively low-key manner at a dinner attended by current College Councillors, as well as past Office Bearers, including all those who have held the office of RANZCOG President in that time.

My column in the previous edition of *O&G* Magazine gave some indication of the way in which RANZCOG is evolving as it enters its second decade, with its sixth Council in place. It can be encouraged by its achievements to date, including the recent extension of its accreditation until December 2013 by the Australian Medical Council that was reported at that time, following its initial accreditation in 2003 for six years and the tabling of required reports since that time. It is striving to deliver more and more in the way of services to all categories of members and it is acutely aware of the role that it plays in ensuring the delivery of *Excellence in Women's Health* to all regions in which it has activities.

The ability to demonstrate insight and work in a targeted manner to improve areas that are perceived as being able to be improved are signs of maturity and growing wisdom and capacity in individuals. Organisations are frequently anthropomorphised and the organic analogy is one of the more frequent metaphors or models that are used to refer to them and explain or predict their behaviour.

In the case of RANZCOG, it is heartening to see the signs of growing maturity visible. It is this that enables priorities to be set, methods of achieving those priorities to be planned, and actions to be taken to influence events. At the organisational level, I have reported previously on the appointment of a Director of Education as part of an evolving organisational structure. Further initiatives and changes at the organisational level designed to enable the College to function as effectively as possible are planned. Organisations must 'have their house in order' in order to continue to function in the sorts of environment we are currently experiencing and they must be cognisant of the expected standards set by their stakeholders.

'This year is shaping already as a time in the evolution of RANZCOG where a number of decisions will be taken and initiatives developed and implemented that will guide the organisation through its next phase of development.'

There are a number of strategic initiatives currently being actively progressed across a range of areas, including: the review and revision of training curricula associated with college training programs, with a forum linked to the upcoming meeting of the College Council to look at the possible ways specialist O and G training may be structured in to the future; the movement of College administration processes to e-formats; the provision to all RANZCOG Trainees of College email addresses; and a new e-platform (*online.ranzcog*) to underpin the delivery of educational resources to Trainees. The implementation of the Conjoint Committee for Obstetrics and Gynaecology (CCDOG), the body involving representation and participation from RANZCOG, RACGP and ACRRM, and which will essentially replace the current Joint Consultative Committee on Obstetrics (JCCO) and report directly to the RANZCOG Council, is progressing, with much to be done through the year to develop a new curriculum for the DRANZCOG and DRANZCOG Advanced qualifications, along with the regulatory and administrative aspects that will underpin these new programs.

A trial of a revised structure to the College Continuing Professional Development (CPD) program is taking shape, with the trial incorporating an on-line mechanism to assist in planning and recording an individual's CPD program. It is anticipated that the framework underpinning the revised program will enable more fully an individual's practice profile to be accounted for, including the different stages of practice that a Fellow may progress through during their career, with a small number of clear and simple guiding principles to the program acting as the 'rules' for satisfactory completion. Recent developments on both sides of the Tasman have reinforced the need for the College to continue to have a robust CPD program that meets expected standards, recognising that participation in CPD by itself cannot absolutely guarantee competence in the workplace setting.

CEO's Message continued on page 9.

CEO's Message continued from page 7.

At an external policy level, the College has contributed to the process surrounding the National Registration and Accreditation Scheme that is currently proposed to come into operation in Australia in July 2010, particularly in regard to the arrangements currently being proposed for medical specialists under the scheme. The President has outlined the main aspects of Australian Government's report on the delivery of maternity services. We will be working hard to ensure that the College has a positive leadership role in the implementation of the recommendations of the report. We continue to liaise actively with the Medical Council of New Zealand regarding matters such as assessment processes for International Medical Graduates, and a recent meeting to discuss a range of matters was held between senior College representatives in New Zealand and the current Minister for Health.

This year is shaping already as a time in the evolution of RANZCOG where a number of decisions will be taken and initiatives developed and implemented that will guide the organisation through its next phase of development. There is a clear feeling from those who are actively involved in the College that much is being progressed, that the College is working hard for the benefit of all members and that the focus is very much on aiding a healthy organisation to continue to grow through what is anticipated to be a very long life.

Facing death

Dr Brett Daniels
RANZCOG Trainee

A/Prof Steve Robson
FRANZCOG

'The idea of death, the fear of it, haunts the human animal like nothing else; it is a mainspring of human activity – designed largely to avoid the fatality of death, to overcome it by denying in some way that it is the final destiny of man.'

Ernest Becker

Of all the topics that occupy us, death and sex have to be at the top of the list. Money might be third. Religion, of course, is intimately bound up with death and sex (and money, too, for that matter) and so pervades all of these topics. Recent issues of *O&G Magazine* have been devoted to these most interesting of subjects: sexuality and religion. As the hot summer succumbs and the chill winds of autumn tickle our necks, we turn our attention at last to the ultimate human preoccupation – death.

Ernest Becker was a Jewish cultural anthropologist who, during US Army service in the Second World War, helped liberate fellow Jews from concentration camps in Europe. Becker had a life-long obsession with death, arguing that much of human civilisation was motivated by our knowledge and attempted symbolic avoidance of mortality. His book *The Denial of Death* saw him awarded a Pulitzer Prize, posthumously as fate would have it.

A wish to avoid dwelling on one's own mortality is likely to be a strong motivator of much human activity, perhaps influencing our choice of career. Fortunately for us, obstetrics is a specialty dealing with relatively healthy young people. However, we must not become inured to the fact that miscarriage is actually death of a human and the grief associated with perinatal loss can be the most difficult to bear.[1] While gynaecology usually deals with benign disease, gynaecological cancers are common and most of us will have had patients who have died from ovarian or cervical cancer.

In this issue of *O&G Magazine* we dial the GPS to the road less travelled. How can we cope with a maternal death? What about near-death experiences? How can we cope with death of a patient during surgery for benign disease? What do we make of stillbirth when there appears to be no cause? We hope that you will find a much broader examination of the topic of death than is usual in obstetrics and gynaecology magazines. As always, we thank our contributors for their insightful words on this most significant of topics.

Woody Allen famously said, 'I am not afraid of death, I just don't want to be there when it happens.' Nor are we at *O&G Magazine* afraid of the subject of death. Death, like tax, is inevitable. With a clever accountant you can minimise your tax bill. Alas, there is no such luck with death.

Reference

1. Raphael B. *The anatomy of bereavement*. 1983; New York: Basic books

Three deaths in six months

One registrar's experience

Dr Natalie Kiesy-Calding
FRANZCOG

It stays with you…I was a fourth year registrar working at a large regional hospital. I had successfully passed my membership exam in the first half of the year and I was feeling that I was finally coming to grips with our demanding specialty.

That morning, I was in antenatal clinic. The first patient of the session was aged in her late twenties at 26 weeks gestation in her second pregnancy. She just 'didn't feel right' and had come to the clinic not complaining of anything specific. Her mother and existing child had come along as well.

The room was set up with the consultation area separate to the examination area. I took her through to the examination area and left her family in the consultation room.

Her blood pressure was 180/110. Urinalysis that had already been done by the midwife showed 4+ proteinuria. So my provisional diagnosis was pre-eclampsia and I did a full exam including listening to her chest, as well as checking reflexes (which were normal) and clonus (which was absent). The fetal heart was 140 and fundal height was appropriate. I sat her up and rechecked her blood pressure which was much the same. My mind was busily turning over how to form the phrases to let her know how serious things were. I had just started to say, 'I think you have pre-eclampsia, which is a dangerously high blood pressure coupled with…' and in the middle of the sentence she suddenly clutched at an area between her shoulder blades. Her eyes turned up, she went pale and then she started fitting. I called an arrest, enlisting the help of the family in the next room, as there was no arrest bell to hand (this has subsequently been rectified) and all the doors were shut.

The team arrived with commendable promptness, by which time (only a few minutes) she was pale and pulseless. All attempts at resuscitation of the woman were ineffectual. A discussion was had about doing a caesarean section in the room whilst we were trying to resuscitate the mother. My consultant made the call that at 26 weeks, caesarean section in this setting was not indicated.

At autopsy she was found to have had a thoracic aortic aneurysm that had burst secondary to the high blood pressures. These were indeed thought to be pre-eclamptic. It was thought that the weakness in the aortic wall was secondary to malnutrition from anorexia nervosa that she had suffered from earlier in her life. It also came to light that there had been alleged sexual abuse from a family member which had triggered the eating disorder. Ironically, it was that same family member that was subsequently most confrontational about her death and most vocal about perceived lack of care.

I remember being led to a side room after the resuscitation by one of my consultants. Everything looked very sharp and clear, like there were fluoroscent lights everywhere. I remember that I kept saying, 'She just died, she just died, she was right in front of me and she just died.'

'In sharing this story, I hope that we are all reminded of our duty of care to our colleagues, without which I may well have succumbed myself.'

I was in this regional centre by myself at the time. I was there for my rural term of 12 months and my husband had stayed at our home in the capital. So when I was sent home early, there was no one there. I don't remember much of the next few days actually, but I think that I was back at work the next day.

I'd like to also relate some extra background. The week before I started work at this regional centre and six weeks before the written membership examination, I was called to give evidence at an inquest on a maternal death that I had been involved with two years previously. This was a non-English speaking multiparous women who had come in at 7:45 am as I was coming off night shift as a (just) second year registrar. A senior midwife had taken her into a birth suite to do a vaginal examination, as she was screaming and appeared to be in strong labour. That was the extent of my involvement with her care prior to the arrest bell ringing at about 8:10 am. At this time we had both the night and day obstetric team, including the consultant of the day in the handover room. We all rushed to attend the patient who was pale and pulseless. Resucitation commenced and a caesarean section was performed in the room during the resuscitation. The baby was born dead and the mother also succumbed. Autopsy was inconclusive, hence the inquest. Nothing more was really learned at the inquest and this death is still unexplained.

So a second death coming on top of this experience (even though it had occurred some two years ago) was very confronting. I went over the events in my mind endlessly, trying to see if there was something extra that I should or could have done. All of my colleagues were amazingly supportive and after the initial few days, professional life started to get back into its groove.

I was then listed about a month later to go to theatre for a hysterectomy, under the supervision of the director of the unit. This was always a great opportunity to operate with a senior surgeon,

so I was very much looking forward to this. The patient in question was perimenopausal and had come in earlier that week bleeding heavily. She had become anaemic, with a haemoglobin around the 7g/L level. She was transfused and medical management instigated with moderate success. Hysteroscopy dilation and curettage (D&C) had been performed earlier to see if there was any intrauterine pathology and if a mirena would be suitable (it wasn't).

A hysterectomy seemed to be the only option as she was continuing to bleed. Accordingly, she was prepared for theatre two days later, with myself and the Director. We were scrubbing up as anaesthesia was being induced, when the arrest bell went off. Again, every effort was made to resuscitate her, but to no avail.

I have a very hazy recollection of events after that. I remember saying over and over again, 'They all die, they've all died'. I remember being held tightly by the Director. Again, I don't remember being sent home, I don't remember much of what I did. I do remember going to a counselling session with a psychologist under sufferance – this had been strongly recommended by the Director, whose opinion I respected. Therefore I had gone, but not I think with an open mind.

Life went on. I went back to work and my husband moved to be with me for the second six months of the year. The second autopsy determined that it was a drug reaction that caused the death and that nothing could have been done. Again, everyone was incredibly supportive and I finished my year before going overseas to do my final two years.

Given the quoted rate of maternal mortality of 8/100,000, 'unlucky' for me didn't begin to cover how I felt. Still being a relatively junior member of the team, as well as being isolated from my family, combined to make the whole experience one that still haunts me. I can feel myself becoming upset as I'm writing this article, years later.

Death is a part of living. In our work with the biological processes of birth and reproduction, it is inevitable that some of our patients will succumb. It is also inevitable that there will be nothing that we can do as doctors to prevent that happening. Doctors working in other specialties with unwell, older patients face these challenges much more frequently. But we are in the enviable specialty where the majority of our obstetric patients are young and healthy. There is also the emotional impact of losing a mother and a child, as opposed to an elderly person with cancer for example. It just shouldn't happen and when it does, it's twice as hard to accept.

As doctors I think we have to remember to be gentle with ourselves and allow ourselves to become upset over loss – we are human as well as professionals. It's alright to grieve over the loss of a patient. I think that it's also very important not to let these feelings take over and to seek professional help to give you the tools to do that. Ultimately however, it's a solitary journey that you make and no one however close to you can 'walk a mile in your shoes' for you.

I was asked by a colleague to write this article, as she was aware of the circumstances that I had found myself in. In sharing this story, I hope that we are all reminded of our duty of care to our colleagues, without which I may well have succumbed myself.

Acknowledgements

With special thanks to Dr Michael Humphrey, Dr Paul Howat and Dr Stephano Kim. Thanks also to my husband Mattias Kiesey-Calding, as well as the rest of my family.

Maternal death

A collection of personal experiences

Collated by
Dr Sarah Tout
FRANZCOG

It is estimated that 600,000 women die globally each year as a result of pregnancy-related conditions. A disproportionate share of these (99 per cent) occur in developing countries, many of which would be preventable with appropriate resources and training.[1]

It is a sad reality though that depending on where we work, how much we work and for how long, we will all have some contact with a maternal death during our careers. Working in the developed world, thankfully, this is a relatively uncommon outcome and it is also that very fact that makes this such a distressing event for all those involved.

As an Integrated Training Program (ITP) interviewer, I frequently hear a similar response to the question, 'What attracts you to the specialty of obstetrics and gynaecology?' I hear the answer, 'It is a happy area of medicine with good outcomes, dealing with young and healthy women.' This is certainly true most of the time and probably has something to do with why many of us chose this area of medicine, but as we are also aware, this is not always the case.

Much more commonly than maternal death, we deal with fetal demise, or intra-uterine death. We are very used to dealing with these scenarios and even though they are always sad, we are better prepared, with protocols and counsellors in place as required. We are also very used to dealing with stressful situations on a busy delivery suite, which we manage on a daily basis using our clinical judgement, skills and knowledge. However, being involved in a maternal death is something we are less well prepared for and it often has a long-lasting effect on us, more perhaps than we would have expected.

This being the case, it was not easy to find someone to write an article on their own experience of maternal death. Instead, I approached a few of my obstetric colleagues, at varying stages in their careers, from trainees, through junior consultants to those approaching retirement. This is a collection of their personal experiences. Some have provided detailed descriptions of the events and others a more personal overview of how they felt and how it affected their practice thereafter.

I would like to thank all those who have very generously put 'pen to paper' and written on what is not an easy topic. I am very grateful for their honesty and believe you, as the readers, will agree that this is an important area to have looked at which is not easily accessible from a text book.

Reference

1. Graham, WJ. Now or never: the case for measuring maternal mortality. *Lancet* 2002; 359:701.

Case 1.
Anonymous

I was still a registrar, working on my elective in a unit where I was given considerable responsibility and hence felt very responsible. My patient was sadly admitted with an intra-uterine death at 29 weeks. This was her first pregnancy and she was devastated. The hospital had strict visiting hours, even for partners, and so that evening she was alone. It was in the early days of misoprostol and her response was extremely effective. She was transferred to delivery suite that evening with perhaps, in retrospect, a hyperstimulated uterus.

Progress was rapid. I was next called to her seizure. I was confronted with a woman not responding and not breathing who had arrested. The crash team was called, basic resuscitation was commenced and I successfully intubated her. The resuscitation was, however, unsuccessful and the family were called. Her postmortem confirmed an amniotic fluid embolism. The next day, at the end of the ward round, my consultant asked me if I was 'OK'. I said I was, continued my day's work and then went home and cried.

I will always remember this woman. I feel quite sad that she died away from her family in such a terrible situation, having just lost her very wanted baby. I think her case continues to bring home to me how important it is to always be caring and compassionate to our patients. It also highlighted to me that sometimes what we do can cause harm and we must be particularly questioning when introducing new protocols, drugs and techniques.

Case 2.
Anonymous

The child lay still and pale on the woven peasant blanket. The evening breeze lifting the dust and dried leaves in the rough yard. Stillness after such noise and bemoaning. Attention, finally summoned.

Labouring alone with the shame of a concealed pregnancy, she had delivered the tiny infant only to succumb to relentless bleeding. The child lay still, pale and dead at just 14 years of age. The feeble newborn barely stirred as we lifted her mother.

Human society can have thick walls to those whose lives do not fit normal expectations. Access to care is a right no one should take lightly.

Fear of discovery for those caught with an unintended pregnancy is perhaps greater than the fear of death itself.

'Every intervention has a risk which must be weighed against the risks of non-intervention in each individual circumstance.'

'...sometimes what we do can cause harm and we must be particularly questioning when introducing new protocols, drugs and techniques.'

Case 3.
Anonymous

She was 23 years old and had been a mother for less than three weeks. Her antenatal course had been uncomplicated, she was not overweight and she had delivered normally, with an epidural for analgesia. Over the previous week she had complained of some backache and had taken herself to her GP and physiotherapist for some treatment.

She then ended up in our emergency department on the Thursday afternoon to be assessed for possible retained products. She had opted to go home for the night and return in the morning for a scan.

I first met her when her mother pushed her into the gynaecology ward in a wheelchair, clutching the scan report and with the baby capsule perched on the handles of the chair. She was crying, in pain and looked pale, almost blue.

Within an hour she was dead, after major resuscitation attempts by gynaecology, medical and (very rapidly) intensive care staff. A post mortem revealed a saddle embolus which, in retrospect, had been causing the symptoms of the previous few days.

She was the classic young, fit, healthy patient who compensates until the last minute. She had no risk factors for thromboembolism and her death, understandably, came as an enormous shock to everyone involved, a salient reminder that, in obstetrics, you can never be too complacent.

Case 4.
Anonymous

She was an attractive, 28-year-old, tall, slightly overweight nurse (BMI 31), whose warm, kindly sense of fun brightened the unit. At 38 weeks after an uneventful antenatal course, there was no fetal heart eight hours after normal fetal movements. The very unfavorable cervix failed to respond to 12 mg of prostin gel, given in divided doses over four days (including rest), despite mifepristone (RU486) being added with the first dose. 100 mcg of misoprostol finally established labour and she delivered a heavily macerated baby 18 hours later. Only acute anoxic changes were found at the baby's postmortem. A thrombophyllia screen was done, as it had recently been identified as a cause of recurrent miscarriage and possibly late pregnancy loss, but we did not think of thromboprophylaxis.

On the tenth day of the puerperium, she suddenly died at home of a massive pulmonary embolus. The following day, a report of severe Antithrombin III deficiency was in my in-tray, dated three days previously – laboratory staff shortages precluding a phoned result.

Lessons

1. Antithrombin III deficiency can kill.
2. Patients with unexplained stillbirth need thromboprophylaxis, until major thrombophyllia has been excluded.
3. Lateral thinking may be blunted by familiarity with the patient.
4. Communications become particularly important when there are staff shortages.

Case 5.
Anonymous

Her third pregnancy had been uneventful but went post-term. The decision for an induction of labour, with her midwife, was routine and a common procedure. The Sunday afternoon progressed uneventfully. Regular contractions established and syntocinon was commenced according to the normal protocol.

An urgent call for assistance was made when there was a sudden maternal collapse and all efforts were made at resuscitation without success. The postmortem confirmed an amniotic fluid embolus.

She was a lifelong friend of a colleague who went on to adopt her children.

The hold on life is tenuous. Every intervention has a risk which must be weighed against the risks of non-intervention in each individual circumstance. Always consider and explain possible complications.

'If a high-risk patient is nursed outside an intensive care area for staffing reasons, changing workloads in the unit must not allow her to be put at risk.'

'Lateral thinking may be blunted by familiarity with the patient.'

Case 6.
Anonymous

A 38-year-old infertile primigravida was booked for an elective caesarean section for a marginal placenta praevia. When the anaesthetist saw her preoperatively, he noted her poorly formed lower jaw and the serious risk of tongue induced apnoea. Her particularly loud snoring had been noted during her previous admission for antepartum haemorrhage (APH), requiring single room accommodation to facilitate other patients' sleep. Elective epidural anaesthesia was rarely offered in that peripheral hospital (30 years ago), but proved very effective.

Due to intensive treatment unit staff shortages, a calculated decision was made to nurse her on the (then) quiet maternity unit. When the epidural wore off, she had a small dose of morphine for pain relief in addition to diclofenac and paracetamol.

Unfortunately, the unit became extremely busy and careful monitoring was temporarily in abeyance. Ninety minutes later, the snoring stopped, because the patient's tongue had occluded her airway. Resuscitation failed when the midwife returned some time later.

Lessons

1. Mechanical obstructive airway disease of the type that can cause sleep apnoea is particularly dangerous postoperatively.
2. Postoperative pain relief can induce an obstructive airways risk similar to the immediate postoperative recovery period.
3. If a high-risk patient is nursed outside an intensive care/high dependency unit for staffing reasons, changing workloads in the unit must not allow the patient to be put at risk.
4. The clinical details in a 'confidential' enquiry may breach patient confidentiality, especially when maternal death numbers are low.

Case 7.
Monique Williams
Midwife

I have only been involved with one maternal near death. The experience is well imprinted in my mind. I can summon up images and feelings around it without much effort.

It was December 2006, just a few days before Christmas. The woman was a primigravida, had been diagnosed with grade four placenta praevia, had had a number of antepartum haemorrhages and had spent the last five weeks in the postnatal ward.

The woman was prepared on the day of her elective caesarean. She'd had all the necessary tests, understood all the preparations and the need for the caesarean to be performed under general anaesthetic. Her partner was present and excited, but also very anxious.

My role at the time was attending elective caesareans as the support person for the family, completing the pre-operative checks and midwifery documentation, attending the caesarean, initial care for the baby, and transfer from the recovery ward back to the maternity postnatal ward.

We had all been prepared for the worst case scenario, which at the time was a possible hysterectomy and some blood loss. The woman had had numerous antepartum haemorrhages which were all closely monitored. We were relieved she had made it to the day of the elective ceasarean when there was adequate staffing and all preparations had been made.

I was feeling quite optimistic about the whole procedure and was attempting to relieve some of the anxiety for the family by being confident and relaxed.

Once in theatre, all the checks were done and the woman was given the general anaesthetic. The baby was delivered quickly, needed minimal assistance and was wrapped and taken out by myself to the waiting father. It was an emotional moment introducing dad to his baby. I was able to say that all seemed to be going well in theatre and we continued upstairs to the postnatal ward to do all the baby checks.

After a while, I went back to theatre to see how the woman was doing and to see how long it would be before she would be awake to breastfeed. As I walked in, I could sense the tension and the quiet efficient manner of the theatre staff and knew that something was wrong. Usually, in theatre there is a sense of joy as a newborn baby is delivered. Everyone is relaxed and enjoys the moment.

Almost at once I could see the amount of blood being called for and the amount of blood she was losing. I was willing to help but the theatre staff were amazing and had everything under control. People came from everywhere to help.

The things I remember are:

- The porters running in with bags of blood after running up and down four flights of stairs and then immediately running to get more
- Theatre nurses counting out bags of blood soaked swabs and the bags lining up around the walls of theatre
- Anaesthetists and anaesthetic technicians being so focused, efficient and capable, not flustered at all, just getting on with all that they could do
- General surgeons arriving and seeing four pairs of hands all trying to work in one woman's abdomen.

I realised how serious the situation was when the emergency trolley was called for and the cardiac compressions were started. I remember standing glued to the wall of the theatre watching all this going on and trying to understand what everyone was doing and thinking. When the cardiac compressions started I thought this is it, we are going to lose her.

All I could think of was that a partner and a baby are going to be left by a loved one and before Christmas. I was thinking about them and was putting myself in their place and how devastating it would be if the woman died.

I felt disbelief that this was all happening before my eyes. I looked at one of the obstetricians performing the surgery. He glanced up and saw me looking horrified and he managed somehow to smile at me. I can't tell you how much relief that gave me and somehow I realised that everything was going to be alright. No one was giving up yet and I prayed that the woman would keep fighting and live for her family.

Soon after this, through the amazing ability of the theatre staff, anaesthetists and surgeons, the bleeding was brought under control.

I found out later that the woman's blood volume had been replaced three times. She had used the entire volume of blood available at the blood bank.

I then thought about what I was going to say to her partner when I get back to the postnatal ward. I was quite stunned by everything and it hit me how close the woman had come to dying as I walked back to the postnatal ward.

I went in to the partner and explained that everything had not been straightforward, but that the she was alright. I suggested that he bring some family in to be with him when the obstetricians were able to come and explain what had happened. My midwifery colleagues were very supportive of me and were really helpful with the partner as well.

I was in the room when the obstetricians came and explained what had happened and was also in the room when extended family arrived, a very emotional time.

The next few days were a bit touch and go for the woman, with further surgery and time in ICU. It was a huge relief to see her make a recovery and move back to the postnatal ward just after Christmas.

I went to visit the woman, her partner and the baby on Christmas Day with a bag of goodies to say I was thinking of them and as I handed the bag to her partner, there were more tears from both of us. About a week later the woman and her family went home.

I think of this family every Christmas and we have caught up a few times since they left the hospital. I am pleased to say they are all doing really well.

It has been an interesting exercise for me to reflect on this experience again. I think often about this experience when I attend caesareans. I don't take the surgery as lightly now and have a renewed respect for our obstetricians, surgeons, anaesthetists and theatre staff.

Case 8.
Dr Ian Page
FRANZCOG

Technically I have been present at one maternal death and one very near-miss death. Fortunately, they both survived and being a pragmatist who moves on I haven't dwelt on either case – except when the occasion to recount 'war stories' to trainees or other senior colleagues arises.

I was the 'surgeon who smiled' in Monique's account of our patient with torrential haemorrhage from known placenta praevia but unknown accreta (see Case 7 on page 18). Why did I smile? Heaven knows, but I guess it was to try and reassure her that, although the patient had almost exsanguinated and required CPR because of it, I still felt we had the situation under some sort of control. Two consultant surgeons, two consultant obstetricians, three consultant anaesthetists – to say nothing of a large support team – might suggest just how little control we really had and how near to losing the patient we were.

'I felt gratitude to everyone in the hospital who had been involved in her care that morning and recognised (again) that I was just part of a large team.'

What was I thinking? Primarily relief, as my conservative tendencies had allowed me to observe quite significant bleeds on a number of occasions during her admission. It was clear that if I had operated on the patient during one of her nocturnal bleeds, I could not have had the support that let us keep her alive. I felt relief too that we had chosen a midline incision, rather than a Pfannenstiel incision.

I felt a little bit of vindication, as not all of my colleagues had been convinced by my willingness to watch and wait, with the patient having had quite significant bleeds, but it is nice under pressure to realise that earlier decisions turned out to be best.

Then I was scared as well – would she die? If she did, would I be viewed as negligent? How would I tell her husband? What would his reaction be? What would everyone else in the hospital think – after all, pregnant women don't die any more, do they?

And what about my colleague who I was assisting? This case was her return to practise caesarean section, just to ensure she was still confident and capable. It wasn't meant to be going so horribly wrong. Would she be alright and still want to help out with our staff shortages or would it put her off? Then how would we run the department?

All those thoughts went through my mind at different points during the procedure. None stayed for long, as there was haemostasis to achieve. What else could we do to stop the bleeding? Would tying off the internal iliacs help and if so, where were they? Thank heavens for the Vietnamese experience of one of my surgical colleagues, who I knew would be able to find them (though fortunately we didn't need to do that).

Finally, after the hysterectomy and with a large pack in her pelvis, she seemed stable enough for us to close and for her to go to the intensive care unit for further excellent teamwork to help pull her through. I felt relief again that we had managed to finish the operation with her alive. I felt gratitude to everyone in the hospital who had been involved in her care that morning and recognised (again) that I was just part of a large team.

Now I will move on to a case of patient who suffered cardiac arrest, but whom we resuscitated. She experienced persistent bleeding after a casearean section under spinal anaesthesia, so for the laparotomy, she was put under general anaesthesia (GA). I went in to help my on-call colleague. The anaesthetic consultant gave the GA, on her last night on-call before moving to another hospital. It should have been straightforward, except for the patient's unexpected allergic reaction to the anaesthetic agents. Severe bronchospasm and cardiac arrest ensued. Cardiac massage was necessary. Could I remember how to do it? Would it be successful? Would I be asked to use the defibrillator – never yet done that, would I do it correctly? Now I was doing it and we seemed to be getting some output. Gosh, it was hard work. After two minutes I needed a break. Fortunately, there were two senior house officers and my colleague present, so we could rotate the task. In between, was there anything else I could do to help? What would we do once spontaneous cardiac output had returned? We still had to stop the bleeding.

I felt more detached with this woman, probably because I hadn't been responsible for the decisions around her care. The need to focus on rarely used skills probably stopped me thinking about much else at the time. But how was my colleague? She looked shattered. Was it alright to leave her on-call for the rest of the night, assuming the woman survived? Should I offer, or would that be patronising?

Well, once cardiac output returned, the bleeding restarted and we undertook a relatively simple and effective hysterectomy. The lady then went to ICU and I slept well. Going to see her the next morning was unnerving. She appeared to have had a major cerebral insult, as she couldn't speak and had strange (athetoid) movements. What had we done? Would she recover? Nobody knew, so it was an anxious day.

'What have I gained in practice? A deeper respect for the value of teamwork at all levels in these critical situations.'

The next morning I felt total relief. She spoke clearly, moved normally, remembered who I was and went home a few days later.

So those are the memories of my two near maternal death experiences. They are still quite vivid when brought out of memory, but otherwise packed peacefully away. What am I most grateful for, apart from the patient's survival? That at the time I had plenty to do, to stop me worrying too much about the gravity of the situation.

Would I have benefited from better preparation about the impact on me of these situations? I don't think so, but who knows for certain?

What have I gained in practice? A deeper respect for the value of teamwork at all levels in these critical situations. We all talk about it, but until I was involved in these cases I don't think I really understood what it meant.

'Communications become particularly important when there are staff shortages.'

Case 9.
Anonymous

In 2004, I 'retired' from acute O and G practice. I had never experienced a maternal death, well not a mother directly under my care, and in the last few months of acute call it crossed my mind a few times. Would that be how my acute call career would finish? How had I been so lucky to escape that most traumatic of maternity events over so many years of practice? I was not so foolish as to believe it was anything but luck that had saved me from this dreadful scenario. I felt blessed when I finished my last day on call and all were alive and well as far as I knew.

I left a fully staffed department (the first time in more than a decade) and felt confident that the 'acute' part of my O and G career was completed. I enjoyed sleeping at night and having weekends with my family but the 'retirement' was short-lived. Less than two years after my 'new life' began, the staffing situation became critical again and I volunteered to help out in the short-term. I felt apprehensive of course, so I went into theatre for a few sessions, reviewed my Advanced Life Support in Obstetrics (ALSO) manual a couple of times and performed a couple of elective caesarean sections with my consultant colleagues, to make sure I hadn't forgotten it all. I also set the ground rules. I must have a consultant available in town in case I needed help and there were some situations I would definitely call them, for example, anterior placenta praevia and caesarean hysterectomy. I wasn't sure I still had the nerve to deal with massive obstetric haemorrhage.

'During the event, there was so much to be considered surgically that little emotion intruded.'

My first day back on call, at the daily department handover meeting, my colleague cheerfully informed me he had a booked caesarean section for an anterior placenta praevia. 'How about you do it and I assist?' he said. This was a perfect opportunity to see if I would keep my nerve in the face of significant haemorrhage.

I met our patient for the first time in the anaesthetic room. Our patient was anxious but entirely aware of the seriousness of her surgery. She was starting a family late in life and was very happy to be bringing new life into the world.

The delivery was straight forward and easy. Nothing had changed about anterior placenta praevias. There was no way around or above the placenta so we went through. The accreta was not unexpected either. I recognised that easily, knew what we had to do without question and what's more, there were two consultants operating so the decision-making was easy as it was shared.

The rest was the surprise: the cervical implantation; the 'snake nest' of huge pelvic veins; the haemorrhage that got worse rather than better with everything we did. It was a frightening but not uncontrolled situation. It was out of the ordinary, so we had to think, reason and go back to basic surgical principles. I initially thought perhaps this was happening because I was out of practice. When I realised my colleague was having exactly the same problems on the other side, I forgot about myself and concentrated on the job. We had to adapt to the situation and try different ways to get control. I felt we would be able to get the haemorrhage under control, we had the best possible help and everything was being done as it should. I heard the anaesthetic team say the cardiac output was low, so they were starting cardiac massage, and an almost detached thought occurred to me that this had the potential to be my first maternal death. Somewhere, an image of talking to the father flashed by but was dismissed to deal with later. There was much we could do yet. During the event, there was so much to be considered surgically that little emotion intruded.

In the next week or two, I spent time considering what we could have done differently and whether I had done my part adequately. Mostly though, my thoughts dwelt on how lucky we had all been. Firstly, the planning had been done well and I had not faced the situation alone at 3am. Secondly, we had such a great team in theatre: the anaesthetic team, general surgical staff, nurses, theatre orderlies, intensive care staff, and laboratory staff all performed their parts of this story to perfection. The key to this success was everybody knowing their jobs well, performing their jobs efficiently and calmly, and communicating well. We had functioned like a team and I was grateful for the many years we had all worked together, which meant we could trust each other's expertise and therefore just get on with our own part.

Going back up to the ward to talk to our patient's husband, I was feeling mixed emotions. I was so thankful to be able to tell him she was alive, but also very mindful that he needed to know she was still critically ill. I felt almost guilty to be happy about her being alive because we had come so close to seeing her die and her husband's happiness would have turned to such sadness. That feeling dissipated as she steadily got better, but my image of having to tell a husband that his wife has died has never gone away. The image was there long before this event and has only been made more vivid by this experience.

I was also very grateful to be able to hand over care to the on coming team 24 hours later and eventually to the postnatal ward staff, who continued great emotional support for the parents. I needed recovery time. More valued support from the team approach.

This delivery is not an experience I want to repeat in a hurry, as I am still acutely aware how close our patient came to dying, but it still feels a privilege to have been a part of such a well-functioning team. It didn't scare me away from acute obstetrics. I am still filling in the gaps on the roster most weeks, but I know there are some days when, if the same scenario occurred, we would not have such a good outcome for many reasons. I also know that should I ever have to deal with a maternal death, no matter how many years of experience I have, it will be difficult and it will take an emotional toll, but nothing like the toll on the patient's family.

Monitoring maternal mortality and morbidity in Australia

A/Prof James King
FRANZCOG

Systematic ascertainment of maternal deaths and the conduct of confidential enquiries into the circumstances and causation of the deaths are fundamental to the assessment of the safety of our maternity services.

This process started in England and Wales in 1952 and UK triennial reports have been published since 1985, with recommendations to the relevant professions about standards of care and practice changes needed to reduce the risk.[1]

Australia was not far behind, having produced triennial reports on maternal deaths since 1964 and some work on selected morbidities has recently commenced. The latest national report addressed deaths in Australia during the triennium 2003-2005[2] but there is concern about the timeliness of these surveys. Even if the report for the next triennium (2006-2008) comes out in 2010 (which is by no means assured), it will be reporting on events which occurred three to five years previously, which may well diminish the relevance of any conclusions and recommendations.

In accordance with that used by the World Health Organisation (WHO), the definition used in Australia includes direct and indirect deaths only, within 42 days of the termination of pregnancy, although incidental deaths are also considered in most reports from individual States and Territories. Late deaths (up to 365 days) are reported by some jurisdictions. It is usually easy to classify a death as a direct or an indirect death (for example, a death from eclampsia in a previously healthy primigravida is unequivocally a direct death, and a death from Eisenmenger's syndrome in a woman who has had corrective surgery for a congenital cardiac defect is unequivocally an indirect death). However, sometimes the distinction is harder to make. For example, is death from suicide, six months following pregnancy, a direct, indirect or incidental death? Currently in Australia, such a case would not be included in the national report because it occurred more than 42 days following the termination of the pregnancy. There is also increasing concern about excluding 'incidental' deaths from consideration because of this difficulty in making the judgement that a death during pregnancy was entirely unconnected with the pregnancy, and as the classification process involves individual judgement, there are inevitable inconsistencies between jurisdictions. For this reason alone, a strong argument can be made from a public health perspective, to have a national uniform approach to the consideration of all deaths in pregnancy and up to the end of the first year after the termination of the pregnancy.

The Australian national reports have used the same definitions since 1973. Over this 32-year period, in Australia, there has been a small increase in the number of births (approximately six per cent), but the number of reported maternal deaths has fallen from 92 to 65, a reduction of nearly 30 per cent. Compared to other parts of the world, the risk of maternal death in Australia is very low, about one death for every 10,000 women giving birth. The maternal mortality ratio (MMR) in Australia is 8.4 per 100,000; in Sub-Saharan Africa, it is 100 times greater, about one death for every 100 women giving birth.[3]

Table 1.

The causes and numbers of direct maternal deaths during the triennium 2003-2005.	
amniotic fluid embolism	8
hypertensive disease	5
thrombosis and thrombo-embolism	5
obstetric haemorrhage	4
others	7
total	29
The causes and numbers of indirect maternal deaths during the triennium 2003-2005.	
cardiac conditions	10
psychiatric causes (including suicide)	6
non-obstetric haemorrhage (for example ruptured cerebral aneurysm)	5
others	15
total	36

Note that psychiatric conditions are the second leading cause of maternal deaths in Australia and it is possible that there may be under-reporting of these occurrences. It is worthwhile noting that there were no deaths in this triennium from termination of pregnancy procedures.

For the first time, the national report for the triennium 2003-2005 did not include any clinical commentary or practice recommendations. It was considered, by the Australian Commission on Quality and Safety, (rightly, in my view) that because of inconsistencies and quality in the reporting from individual States and Territories, no meaningful conclusions or recommendations could or should be made. Until there is a uniform, consistent approach by a single central, properly authorised confidential committee, no valid clinical conclusions or recommendations are possible, which puts Australia far behind the process undertaken by the UK Confidential Enquiry into Maternal and Child Health.[1]

However, isn't this good news, that the numbers in Australia are very small and appear to be declining? Well, surely that is so, but as is so often the case, a superficial look at the data doesn't tell you the whole story, and there are several reasons to be concerned about maternal mortality and morbidity in Australia.

We need first to ask, how good are the data? There is a concern about under-ascertainment. As distinct from a stillbirth or a neonatal death, there is no mandatory notification of maternal mortality, although some States and Territories have a 'tick box' for notification that the deceased has been pregnant within the preceding 12 months. It is generally held that in the absence of coordinated efforts to maximise ascertainment, maternal deaths are underestimated by as much as 30 per cent. Some States undertake such efforts, but as is so often the case in public health surveys in Australia, there is variation between States and Territories in the approach to ascertainment. Failure to notify might be more likely for deaths in early pregnancy and when the death occurs remotely in time and/or place from the birth or termination of the pregnancy.

There is also variation and inconsistency in the way in which maternal mortality committees function in Australia, with respect to consideration, classification and reporting of maternal deaths. For example, in the compilation of the most recent report on maternal deaths in Australia, it appeared that there was no functioning maternal mortality committee in Queensland, which was the State with the highest MMR in Australia (over the previous twelve years).[2] Only some States consider and report on preventability. Other States refrain because of privacy or other concerns. There are also variations in referrals of these deaths for coronial investigation. From 2003 to 2005, only 47 of 65 deaths were reported to the coroner, and only 19 of the 29 direct deaths were referred to the coroner.[2]

There are also concerns about the quality of data indicating Indigenous status. In the 2003 to 2005 report, data on Indigenous status was missing in eight per cent of maternal deaths. This deficiency is of special importance because the MMR for Indigenous women was 21.5, compared with 7.9 per 100,000 for non-Indigenous women, reflecting their health disadvantage, in pregnancy and childbirth, as it is in all areas of health of Indigenous groups.

There are other good reasons why we need a systematic national approach to identify, consider and report on causation of maternal mortality. The risk profile of women giving birth is changing. Obstetricians, general practitioners and midwives are now dealing with:

- older women embarking on pregnancy, particularly older/nulliparae, who are more likely to have underlying cardiovascular disease;
- more pregnancies as a result of assisted reproduction techniques, especially more multiple pregnancies;
- more obesity[3];
- more hypertensive disease;
- more gestational diabetes; and
- more thrombo-embolism.

Furthermore, there are more women entering pregnancy with a history of prior caesarean sections, with the attendant risks of placenta praevia and placenta accreta, and severe peripartum haemorrhage.

It is estimated that for every maternal death, there are approximately 80 instances of severe maternal morbidity, in which the woman experiences a life-threatening complication from which she survives (completely, or sometimes with residual injury).[4] Such severe morbidities include haemorrhage requiring blood transfusion, uterine rupture, eclampsia, renal failure and other conditions involving transfer to a designated intensive care unit.

In acknowledgement of the importance of addressing severe maternal morbidity, in 2008, the Australian National Health and Medical Research Council funded the establishment of the Australian Maternity Outcomes Surveillance System (AMOSS), based at the Perinatal and Reproductive Epidemiology Research Unit at the University of New South Wales. AMOSS will collect data on a range of serious but rare complications and disorders of pregnancy, which are thought to contribute significantly to the burden of maternal morbidity in Australia. This will add significantly to our understanding of risks and complications of pregnancy, and will advise clinicians about these risks and how the occurrences may be reduced.

A concerning aspect of maternal mortality monitoring in Australia is the lack of recurrent funding or a permanent auspicing agency. The last national maternal mortality report carried a foreword signed by the Director of the Australian Institute of Health and Welfare (AIHW), which auspiced and authorised the report that contained this statement:

> '..the (Australian) Commission (on Safety and Quality in Health Care) is not able to provide ongoing funding (for regular reporting of maternal deaths in Australia) and it is concerning that no resources have been identified to sustain and improve this reporting in the future.'

An options paper to obtain a firm footing for the national maternal mortality survey has been prepared by the AIHW and submitted to the Commission on Safety and Quality in Health Care, but no response had been received at the time of preparing this article.

Given the profound tragedy of the death of a woman in pregnancy, childbirth or the puerperium, and the ripple effect such an event has on the immediate and extended family, even to the next generation, surely Australia should be able to proudly proclaim that it takes these occurrences extremely seriously, that it has a consistent, comprehensive approach to ascertainment, confidential enquiry and reporting of maternal deaths, with consideration of all instances by a legally mandated and protected panel of experts. The recommendations of this panel should be available to policy makers, funders and providers of healthcare for pregnant women, as well as to the public, so that we can reassure the childbearing population and their relatives that every effort is made to prevent these catastrophic events.

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Maternal mortality in New Zealand

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The review of maternal deaths in New Zealand has had a chequered history. In the 1950s, there were reviews into specific conditions such as eclampsia and haemorrhage. From 1959, there was a review of maternal deaths undertaken by Professor Lawrence Wright. However, notification and detection of cases was a recognised problem. A more structured approach was developed over the next ten years. The *Maternal Mortality Research Act 1968* gave a legal framework by establishing a Maternal Deaths Assessment Committee; secretarial support; a number of regional assessors; a requirement on practitioners to provide information; payment for practitioners supplying information; secrecy of information; and protection for those acting under the authority of the Act.

The committee was chaired by Professor Dennis Bonham and issued intermittent reports, including cumulative data on deaths from 1969, although it was known that year was incomplete. Indeed, a recurring matter raised by the committee was late or non-notification of cases. This delayed case review and, importantly, delayed the feedback to individual clinicians and health services. Reporting on this was seen as an important part of the committee's work.

By 1990, the Maternal Deaths Assessment Committee had grown to include consumer input, as well as obstetric, pathology, anaesthetic, general practive and midwifery contributions. At one stage, a physician was co-opted. Professor Don Aickin took over as Chair in 1990. In a comment on deaths from 1986 to 1998, Professor Aickin reported (in 1993) that New Zealand had different definitions of maternal deaths and different denominators to Australia and the United Kingdom. New Zealand used mortalities within three months of pregnancy, while Australia and the United Kingdom included only deaths within six weeks of birth. In New Zealand, the denominator was total births, in Australia total confinements, and in the United Kingdom total maternities. Thus, comparisons could only be made with allowance for these differences. However, it appeared that rates of death in New Zealand in the mid 1980s were higher than in Australia and the United Kingdom, with changes in options in maternity care occurring as a result of midwifery practice. Professor Aickin drew attention to a decrease in the rate of direct obstetric deaths after the triennium 1975-7, but a rise in 1986-8, particularly sepsis. He concluded that 'the current changes in provision of maternity services indicate a continuing need for careful analysis of outcomes'.

In addition to changes in maternity care, this was a time of 'health reforms'. The review of maternal deaths was not a priority of the New Zealand Health Minister and the Ministry of the Health. A number of practitioners had been charged with manslaughter where death was involved. While eventually the *Crimes Act* was amended in this regard, the background inhibited reporting of cases. The last report of the committee was in May 1996, reporting on the triennium 1989-91. Thereafter the committee was in abeyance and although it was resurrected in 1999, it did not function, despite the best efforts of the by now combined Royal Australian and New Zealand College of Obstetricians and Gynaecologists.

Another decade, another political party leading the New Zealand Government and more legislation, this time the *New Zealand Public Health and Disability Act 2000*. A section enabled the Health Minister to appoint one or more mortality review committees. A schedule to the act contained provisions as to how they should function and only the Health Minister could authorise disclosure of information. The first mortality committee to be established was the Child and Youth Mortality Review Committee. A lengthy consultation process resulted in the formation of the Perinatal and Maternal Mortality Review Committee, which met for the first time in August 2005. Initial efforts were focused on establishing a system for reporting perinatal deaths and since 1 July 2006, information has been collected on nearly all perinatal deaths. All District Health Boards have local coordinators to review their own cases and report on classification of deaths. The committee established a Maternal Mortality Review Working Group which met in October 2006. With the appointment of a national coordinator and the network of local coordinators, work began on the systematic review of maternal deaths for the first time in many years. While the Ministry of Health had issued figures each year of known maternal deaths, there remained unease that the figures were incomplete and there had been no review of cases nationally. There remains the problem of late or non-notification. However, the cases are a tragedy for surviving families and for those providing care. The cases contain lessons for improving care and healthcare systems.

The Working Group has completed a review of cases for 2006 and most of 2007. A draft report has been completed and release is awaited shortly. Many people have an interest in the outcome. A Maternal Mental Health Workshop for professionals was held in October 2008.

From 2009, all death certificates will include a question about recent pregnancy. This should improve identification of cases.

There is a changing professional attitude to these sorts of inquiries. Although there are still potential consequences when there is a bad outcome, via the Health and Disability Commissioner, Health Practitioner Disciplinary processes, Medical Council competence review and other processes, the need to review cases is accepted. The Maternal Deaths Assessment Committee has a number of professionals providing time and staff to enable it to function.

Declaration
The author is a member of the Maternal Death Review Group. He was a regional assessor for the Maternal Deaths Assesssment Committee from 1990. He was invited to join the committee as an observer in 1999 but the committee did not meet after that.

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Deaths following gynaecological surgery for benign conditions

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Whilst we all have a healthy concern regarding the potential for one of our patients to die as a consequence of performing gynaecological surgery on them, the likelihood that we might meet such an unfortunate outcome is, thankfully, small.

However, it behoves us all to develop and put in place protocols and procedures that will minimise harm at surgery. We should also have strategies in place for identifying, in a timely manner, the development of any complications following such surgery.

The 2005 joint report from RANZCOG and United Medical Protection[1] (UMP) indicated a number of important features that emanate from legal claims:

- More than 50 per cent of laparoscopy-related claims are from thin women (although undoubtedly obesity is a major risk factor for poor outcomes).
- Laparoscopy and hysterectomy procedures constitute the majority of claims.
- Death only constituted one per cent of claims (although this does not necessarily reflect the incidence of death from gynaecological surgery).
- Delay in diagnosing adverse outcomes constitutes a significant proportion of the claims.

'It is essential that, early in our careers, we learn to develop and update well-defined protocols and strategies in relation to our surgery.'

History

Modern surgery is highly sophisticated, often utilising the full gamut of antibiotics, blood transfusion, advanced anaesthetic skills, intensive care facilities and advanced surgical skills. Modern surgery also tends to be more complicated and utilises more complex equipment than previously. In addition, we are prepared to operate on women with more complex health problems than in the past. This is a trend that is likely to continue. With this in mind, it is worthwhile briefly reviewing some historical data. In 1948, Weir[2] reported that 40 out of 1771 hysterectomies ended in death (2.25 per cent). In 2001, Varol *et al*[3] reported on a ten-year review of mortality and morbidity from hysterectomy in an Australian teaching hospital, indicating a mortality of 1.5/1000 (0.15 per cent).

However, as in obstetrics, mortality is the 'tip of the iceberg' of overall morbidity. It is a crude indicator of adverse outcome.

Morbidity constitutes the majority of the clinical headaches (and medico-legal issues[1]) that we must deal with. As such, the development of strategies to minimise morbidity will also help to address the ultimate complication of mortality.

Managing risk

It is not my intention to focus on death rates from individual procedures but, rather, to pose the question: How do we deal with managing risk in the widely disparate clinical settings in which we practise – single practitioners, groups, associateships and partnerships, small provincial hospitals, large regional hospitals, university teaching departments and specialised subspecialist units? Ideally, risk management should start with our training as registrars, guided by our teachers. After that, we acquire specialised skills by continuing to learn in a myriad of ways (see Table 1). These steps are what most of us have followed throughout our career. A very good overview of the issues facing surgical training in our specialty is addressed in an article by Thierry Vancaillie in the AGES newsletter of July 2008[4], and merits reading by all who train, supervise or mentor for gynaecological surgery. It is clear there are a number of significant issues facing our Trainees and Fellows who seek to gain and maintain well-defined skills in gynaecological surgery.

Table 1. Steps to surgical skills acquisition.

- Adequate exposure to surgical training as a registrar
- Preceptorships – having an expert to operate with you
- Specialised surgical courses – laparascopic, AGES courses, etc
- Anatomy of complications course – Prof Ian Hammond, Perth, WA
- Audit and review of surgical outcomes
- Operating together with a specialist college.

What are the issues that contribute to error? Recently, much has been written about the area of risk management in healthcare, but it would not be possible in this short article to cover the whole subject of risk management in gynaecology. Nonetheless it is something that all of us are going to need to incorporate into daily practice. Therefore, it is essential that, early in our careers, we learn to develop and update well-defined protocols and strategies in relation to our surgery.

The 2009 Productivity Commission report[5] on health indicated that 124 out of 187 of the 'core sentinel events' recorded were surgical, with procedures being performed on the wrong body part, or retention of instruments or other material necessitating re-operation. In reality, these figures will only be part of the whole spectrum of

adverse outcome that are not recorded, as there is no structured process to aid the recording of adverse outcomes in Australia.

Identifying risk

There have been frequent references in medical literature referring to the risk management strategies utilised by the aviation industry, suggesting that healthcare could look to the example of the aviation industry for direction in developing effective tools to monitor and assess adverse outcomes. The outcomes of such a process should help us to minimise the risk of harm occurring to our patients.

There are now surgical audits in most Australian States assessing all surgical deaths. The first audit started in Western Australia in 2001[6], based on the Scottish Audit of Surgical Mortality and Morbidity, and is covered by legislated qualified privilege. In fact, many of us might have had some involvement in such audits as i) the surgeon involved, ii) a first line assessor, or iii) a second line assessor. It is sometimes quite sobering to be involved. Importantly, such audits might in fact validate our practice. The audit process feeds information back to the surgeon involved. The first Western Australian audit indicated that 83 per cent of emergency and 68 per cent of elective surgery-related deaths had no deficiencies of care, which is news that involved surgeons would be relieved to hear. This study has resulted in 73 per cent of surgeons modifying their clinical practice.

The December edition of *BJOG*[7] published its first ever article on a critical analysis of an adverse surgical outcome. The accompanying editorial comment merits reading and the link to the site (www.chfg.org) is worth visiting to look at the anaesthetic case.

Obviously, there is a evolution of risk management in medicine where autonomous practice was once the norm. Although most of us find the concept of extra documentation and audit tedious and time consuming, it is in our interests to become involved. Regulatory bodies are moving to incorporate such systems into routine medical care. Medical indemnity organisations now acknowledge that the introduction of risk management into clinical practice has reduced the medico-legal burden on the profession, and hence the cost of practice and our stress levels.

Table 2. Factors involved in adverse outcomes.

- Fatigue, personal stress, medication, alcohol
- Time of day
- Complexity of surgery
- Complexity of equipment
- Health status of patients
- Personality traits of doctor
- Human interaction in operating theatres.

Where to from now?

As the causes of adverse outcome of surgery are multifactorial, then the means by which we minimise harm are many. Table 3 indicates a (not exhaustive) list of suggestions.

All of us understand that surgery is inherently potentially linked to adverse outcomes, some of which are unavoidable in spite of best practice. However, all of us as practitioners can improve our practice, it is just a question of how much work we are prepared to put into our own form of risk management, within the professional structure that we practice in.

Table 3. Strategies to reduce adverse outcomes.

- Assess the need for and type of surgery carefully.
- Prepare yourself well regarding sleep, medication issues etc.
- Use protocols and evidence-based medicine to guide practice.
- Use care when doing new procedures or using new equipment.
- Don't overload operating lists.
- Use the 'time out' process before starting.
- Do the correct procedure on the correct side etc.
- Know your equipment and how to troubleshoot problems.
- Work with a regular group of theatre staff.
- Recognise your limits.
- Don't delay asking assistance from a colleague.
- Operate regularly with a colleague for major procedures.
- Ask a colleague to assist with a return to theatre.
- Make sure ward staff know how to monitor your patients.
- Deal with complications quickly.
- Audit outcome.

As an example, in our group of six O and Gs, we operate together regularly. In addition, we try to avoid public hospital on-call duties prior to an operating list the next morning. If there has been a busy private obstetric load leading up to the day of operating, we might arrange cover for the night before if the caseload is complicated. Some of our group have well-developed skills in particular procedures and will support performance of those procedures by others of us. Should we return to theatre with a post-operative bleed, large on-going postpartum haemorrhage (PPH), or other such event, then we will ask one of the group, who has no vested interest in the patient, to accompany us.

In summary, the issue of death from gynaecological surgery represents just part of the spectrum of adverse outcomes. Many well-developed processes have been produced to aid clinicians' efforts to improve outcomes for our patients. However, implementation of these strategies requires that we be part of the process. Better that than have the formality of risk management imposed on us in a way we are not able to influence. It is important we demonstrate to the public that as gynaecologists, we are seriously addressing the welfare of our patients.

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Investigations at stillbirth

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Investigating a stillbirth is like attempting to solve a mystery with a variable number of clues available. Information comes from different sources. As clinicians involved in the care of women who lose babies in pregnancy, we must remember that, while supporting women through this traumatic time, we also need to be looking for answers as to why this has happened.

Women and their families will also be looking for ways to ensure a successful outcome in a future pregnancy.

Sometimes answers may be obvious, other times we may never know why a stillbirth has occurred. However, generally, the more information available, the more readily we are able to put the clues into some sort of order.

While the optimal evaluation of a stillbirth is controversial and is influenced by medical and non-medical factors, it is noteworthy that the proportion of stillbirths that are 'explained' is much higher in centres using systematic evaluation for recognised causes and potential causes of stillbirth.[1]

Back to basics

Keep good medical records for all patients. Document maternal age as well as height and weight at the beginning of each pregnancy in order to complete customised growth charts and you may detect a growth restricted baby at risk of perinatal mortality.[2] The risk of stillbirth is almost twice as high among obese pregnant women compared with normal weight pregnant women.[3]

A thorough history is vital to investigating a stillbirth and the person who sees the woman first is often in the best position to get the most recent history. How have movements been? Has there been any bleeding or fluid leakage? Has there been any trauma, or, amongst some Pacific Island cultures, any traditional massage? Has the mother had a viral illness or is there any past medical, family or obstetric history of note?

Ultrasound

Most stillbirths are confirmed by ultrasound examination and a scan can also be useful for giving other information. Is the liquor volume normal? Size, anatomy and placental location may also add to the 'clues'. If a chromosomal abnormality is suspected or there is a possibility of infection, amniotic fluid can be taken by amniocentesis and sent for cytogenetic assessment or microbiology and virology culturing.

Maternal blood investigations

These should be requested as close to the diagnosis as possible. Hospitals will vary in the standard tests they request, but most would accept the following as a baseline:

- Full blood count including white cell count and platelets
- Group and antibody screen
- Kleihauer
- Rubella, Hepatitis B, *VDRL and HIV if not already performed in booking bloods
- HbA1c
- Polycose and/or glucose tolerance test (GTT)
- Thyroid function tests
- Thrombophilia screen
- Antinuclear antibodies
- Lupus anticoagulant
- Anticardiolipin antibodies.

Serological investigations for intrauterine viral and protozoal agents, including toxoplasmosis, cytomegalovirus, herpes simplex and parvovirus, are of little clinical benefit.[4]

Following delivery

A thorough examination of the baby, placenta and cord are important, especially if postmortem (PM) has been declined. Birth weight and measurements of head circumference, crown-heel length, crown-rump length and foot length should all be recorded. The degree of maceration, the colour of the baby and the amount of subcutaneous fat should be noted.

An excellent check list for baby examination findings can be found on the Perinatal Society of Australia and New Zealand Perinatal Mortality Group (PSANZ PMG) website.[7]

The placenta

Examination of the placenta is an integral part of the baby examination. Look at the membrane colour and integrity. Are the chorionic vessels empty, full or normal? Is there any scarring or haemorrhage on the maternal surface? Does the parenchyma appear loose and pale or firm? Look at cord insertion, length and colour. Check for knots, areas of compression or haemorrhage into the matrix.

Placental histopathology alone can give a cause for stillbirth in up to 30 per cent of cases and consent should always be sought, even if consent for PM has not been obtained.[7] Histological evaluation of the placenta, membranes and umbilical cord can provide insight into varied potential aetiologies including infection, genetic abnormality, anaemia and thrombophilias.[3]

Microbiology

Placental swabs can be useful, but are best if taken from between the membranes. Swabs taken from the maternal surface will be contaminated by maternal vaginal flora and of little use. As mentioned, amniotic fluid can be sent for microbiology and virology if taken at amniocentesis.

** Venereal Disease Research Laboratory (VDRL)*

If the baby is not for PM take pharyngeal swabs. Stomach and lung swabs will be taken at PM.

Clinical photographs

Clinical photographs are an important aid to diagnosis, especially if PM is not consented to. Photos need parental consent. Once more, the PSANZ PMG website has excellent instructions for taking appropriate photographs.

Cytogenetics

Fetal karyotype is valuable, especially in cases where PM is not being performed. If an amniotic fluid sample has been taken before delivery then further samples need not be sent. Otherwise, send cord blood or cut a clean sample of placenta from the fetal side and a one centimetre piece of umbilical cord, and send in saline or transport media.

Postmortem examination

Postmortem examination is the single most useful diagnostic test in investigating a stillbirth and is offered to all women in our hospital. When PM is performed, up to 69 per cent of stillbirths can be explained, compared with 56 per cent when no PM is performed.[5] In addition to the identification of birth defects and morphologic abnormalities suggesting genetic or developmental abnormalities, PM can determine and/or confirm numerous other causes of stillbirth. Examples include infection, anaemia, hypoxia and metabolic abnormalities.[3]

'A thorough history is vital to investigating a stillbirth and the person who sees the woman first is often in the best position to get the most recent history.'

From our hospital in New Zealand, babies are flown to Wellington for PM, an hour's flight away. Despite this need to transport babies via escort in an aeroplane, the offer of PM is regularly accepted. The service is prompt. Babies are treated with the utmost respect and the findings are presented by the pathologist, who attends our monthly perinatal mortality meeting.

We have learnt that it is important never to assume that a family will want or not want a PM. All parents should be given the opportunity to make an informed decision with regard to PM examination of their child.

When offering a PM you need to be able to answer questions that the family may have: how long will the procedure take, where will my baby be cut, what will he/she look like afterwards? Parents should expect to be able to discuss the PM with an informed person once the results are available. They should expect to be able to see the baby following the PM and to attend a debriefing session with an obstetrician within two months of the death.

Despite the best of counselling, families may still refuse PM examination. Reasons for refusal include concerns around disfigurement and further suffering for the baby. There may be objections from family members for religious or cultural reasons.

Magnetic resonance imaging (MRI)

MRI (if available) can be offered if PM is refused. It has advantages and disadvantages, being more readily accepted by some patients, but without the tissue examination of a PM. The diagnostic accuracy is also less than PM, with, in one study, ten of the 18 abnormalities found in PM being detected on MRI.[6]

Summary

We investigate stillbirths for a number of reasons. Giving parents an answer can help with closure as they mourn the loss of their baby. It is important to use whatever information we have gathered to help them plan for a subsequent pregnancy.

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Unexplained stillbirth

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More than three million babies are stillborn across the world each year.[1] Although the majority of these losses occur in developing nations, stillbirth remains a common adverse outcome in countries such as Australia and New Zealand, where the incidence is about one in 200.[2]

Careful investigation to determine the causes of a stillbirth is important as knowledge of the aetiology allows informed counselling about risks faced in a subsequent pregnancy and planning of management strategies.[2,3,4]

Unfortunately, no cause for a stillbirth can be found in as many as one-third of cases.[2] This situation is usually referred to as 'unexplained' stillbirth. There are many coding systems used to classify causes of perinatal death and stillbirths should only be deemed 'unexplained' if complete investigation fails to yield a cause. The Perinatal Society of Australia and New Zealand (PSANZ) has recommended a set of investigations for stillbirth (see Table 1). Regrettably, for various reasons, investigation is incomplete for many fetal deaths and the term 'unexplored' stillbirth is probably more appropriate.[5]

'...studies did find that pregnancy after stillbirth is characterised by increased rates of induced labour, elective and emergency caesarean section, preterm birth and low birthweight.'

Unexplained stillbirth is an enigma. Numerous population-based studies have defined risk factors for this condition (see Table 2), yet extensive research efforts over two decades have not led to any reduction in the incidence of this disastrous outcome.[2,6] Most of the published literature is concerned with population-based strategies for primary prevention of unexplained stillbirth. Unfortunately, many of the risk factors are not easily amenable to modification – lower socio-economic status, maternal age and race for example. Other risks such as maternal obesity, smoking and diabetes are routinely addressed during antenatal care anyway. Since the rate of stillbirth is not decreasing, the commonest issue facing providers of antenatal care is what to offer women in their next pregnancy.

What happens in the next pregnancy after unexplained stillbirth?

Overall, the odds ratio for recurrence of stillbirths from all causes is almost five[7], but studies of pregnancy outcomes subsequent to unexplained stillbirth have not reported any significant increase in the adjusted risk of perinatal death compared to women who have not suffered a stillbirth.[8,9,10,11] This should be reassuring news for women. However, those studies did find that pregnancy after stillbirth is characterised by increased rates of induced labour, elective and emergency caesarean section, preterm birth and low birthweight. This may be an example of a phenomenon known as the Hawthorne Effect: when a severe adverse outcome (such as stillbirth) occurs, clinicians will be exceptionally cautious in the next pregnancy, usually maintaining intense surveillance and a low threshold to intervene. Thus, the management in the next pregnancy is fundamentally different and cannot be easily compared with what happened first time around.

Table 1. PSANZ recommended investigations for stillbirth.

At the time of diagnosis of intrauterine fetal death
• Ultrasound scan to detect possible fetal anomaly and to assess amniotic fluid volume
• Amniocentesis for fetal karyotype
• Low vaginal swab to culture for aerobic and anaerobic organisms
• Full blood examination
• Serology for cytomegalovirus, toxoplasma, parvovirus B19
• Rubella and syphilis serology
• Blood group and antibody screen
• Kleihauer-Betke test
• Renal function including uric acid
• Liver function tests
• Anticardiolipin antibodies
• Lupus-like anticoagulants
• Activated protein C resistance.
At birth
• Swabs from the fetal ear and throat
• Detailed pathological examination of the placenta and membranes
• Perinatal autopsy
• Fetal blood sample for infection and karyotyping
• Clinical photographs.
Before discharge
• Fasting blood glucose, with full glucose tolerance test if increased fasting level or history is suggestive of diabetes
• At 8 to 12 weeks post-natal
• Anticardiolipin antibodies
• Activated protein C (APC) resistance if not undertaken at birth
• Factor V Leiden mutation (if APC resistance positive)
• Fasting homocysteine
• Proteins S and C deficiency.

Our own study of women who have suffered an unexplained stillbirth found that they want high levels of surveillance and early delivery in their next pregnancy.[12] Both women and obstetricians seem to want the same pattern of care in the next pregnancy. It is not surprising that Australian data show that rates of induced labour and elective caesarean section are increased in this setting suggesting a strong Hawthorne Effect.[9] Although early delivery would be expected to reduce the rate of stillbirth at a population level, it increases the potential for iatrogenic complications such as prematurity, failed induction, instrumental delivery, emergency caesarean section and post-partum haemorrhage. While these are undoubtedly preferable to stillbirth, they are still adverse outcomes.

Pre-pregnancy

It is common for women and their partners to try for another pregnancy soon after stillbirth. Older studies have found that almost half of such couples are pregnant within six months.[13] For this reason, timely consultation with the couple before attempting pregnancy again is very important. Since many stillbirths classified as unexplained are actually incompletely investigated, it is important to carefully review results of all investigations and inform the couple where areas of uncertainty lie. A clinically useful way of looking at this is to describe stillbirths as unexplained but non-recurrent (where investigation was sufficiently complete to exclude aetiologies with a risk of recurrence), or unexplained but potentially recurrent (where the level of investigation makes it impossible to assign a prognosis).

In any case, before attempting pregnancy again, maternal conditions increasing the risk of stillbirth recurrence should be sought: hypertension, thyroid and chronic renal disease, diabetes, thrombophilias, lupus, blood group antibodies and hyperhomocysteinaemia. If found, attempts can be made to stabilise the conditions before the next pregnancy. Rarely chronic infectious conditions associated with stillbirth are diagnosed, the commonest being toxoplasmosis, syphilis and possibly chlamydia.[14] There is some evidence from animal models that periodontal anaerobes might cause stillbirth, so dental review is advisable.[15] Women at social disadvantage can be offered additional social supports, but admittedly, evidence of the effectiveness of such interventions is equivocal.[16] Obesity and smoking are important modifiable risk factors for adverse outcome in the next pregnancy.

It is worth noting that timing of the next pregnancy can play a role. Women who conceive within 12 months of a perinatal loss seem to have higher rates of depression and anxiety.[17] These emotional states have the potential to influence pregnancy outcome since management of maternal anxiety and depression may reduce the risk of preterm birth and possibly other adverse pregnancy outcomes.[18,19] Pathological grief responses can be difficult to pick, so formal assessment of the couples using instruments, such as the Edinburgh Postnatal Depression Scale[20] and the Spielberger State-Trait Anxiety Inventory[17], might identify those needing referral for further psychological assessment before pregnancy.

Table 2. Risk factors for unexplained stillbirth.

• Maternal age greater than 35 years
• Smoking
• Obesity
• Socio-economic disadvantage
• Indigenous status
• Increasing parity
• Previous small for gestational age
• Diabetes
• Anaemia
• Periodontal disease.

Management in early pregnancy

There are no data addressing the risks, if any, that women face in early pregnancy after an unexplained stillbirth. Notwithstanding, early ultrasound is important to accurately establish the gestational age. The most effective intervention for reducing the rate of stillbirth is likely to be timely delivery, once the fetus is mature, probably no later than 39 weeks gestation.[2,21,22,23] Induction of labour is likely be offered in these pregnancies and adverse outcomes (emergency caesarean delivery, instrumental delivery and post-partum haemorrhage) are related to either attempted induction at an early gestation or in older age groups.[24] Accurate determination of gestational age with ultrasound as early as possible reduces the risk of inadvertent premature delivery and failed induction.[25]

'...before attempting pregnancy again maternal conditions increasing the risk of stillbirth recurrence should be sought...'

Abnormal fetal karyotype may have remained undiagnosed even with careful work-up at the time of a stillbirth. Failure of cell culture is common when there has been a delay between death and delivery. The commonest conditions associated with fetal death are trisomies 21, 18 and 13, and these may impart an empirical recurrence risk of between five and 15 per cent, depending on the age of the woman.[26,27] Since invasive karyotyping increases the risk of pregnancy loss, care must be taken counselling younger women. Where a fetal karyotype could not be obtained from the stillbirth, young women should be offered risk estimation using combined first trimester screening with resort to invasive karyotyping as indicated by screening results.

Management in later pregnancy

Most women who have had an unexplained stillbirth will seek 'increased fetal surveillance' and 'early delivery' in subsequent pregnancy, although a desire for elective caesarean delivery is uncommon.[12] Such a pattern of care is likely to be promoted by obstetricians as well.[28] The methods of surveillance commonly undertaken are regular ultrasound, cardiotocography (CTG) and fetal movement surveillance.

Growth restriction seems to be a factor in many unexplained stillbirths[29], with failure to identify growth restriction a common factor.[30] Antenatal measurement of symphysio-fundal height, though almost universal, is of limited value in screening for growth restriction.[31] For these reasons, it would seem prudent to offer regular fetal ultrasound for the detection of abnormal fetal growth because growth restriction is a final common pathway for many pathological processes. Uterine artery flow measurement by Doppler has been shown to be a useful predictor of stillbirth related to growth restriction up to 32 weeks gestation, but such testing is of limited value in later pregnancy.[32]

Use of ultrasound-based fetal weight estimates can be falsely reassuring.[33] The use of customised centile charts has been found to be a better predictor of fetal growth restriction and stillbirth. There is no evidence yet that prospective use of such charts reduces the rate of perinatal death in screened populations.[34] A better screening

tool in later pregnancy is umbilical artery Doppler study. Screening of high-risk populations using this method is the only strategy associated with a trend toward improvement in perinatal mortality.[35] Unfortunately, the optimal frequency of such ultrasounds remains uncertain.

Regular CTG testing to establish 'fetal wellbeing' is very commonly practised, yet there is little evidence to support it. The only study of CTG surveillance in pregnancy after stillbirth showed no effect on perinatal mortality.[36] Meta-analysis of studies of regular CTG testing in 'high or intermediate risk' pregnancies actually detected a paradoxical trend to increased perinatal deaths.[37] On the basis of current evidence, routine CTG testing undertaken as a screening strategy, in the absence of specific clinical concerns such as reduced fetal movement, is unlikely to benefit women.

'Women who conceive within 12 months of a perinatal loss seem to have higher rates of depression and anxiety.[17]'

A time-honoured method of fetal surveillance is formal fetal movement charting, commonly aided by 'kick charts'. This should be no surprise, since many cases of intrauterine fetal deaths are preceded by a decrease in fetal movements, often for up to a day beforehand. A wide variety of adverse pregnancy outcomes seem to be associated with reduced fetal movements.[38] Unfortunately, the use of 'kick charts' in prospective studies have failed to demonstrate any effect on the rate of perinatal mortality.[39] That study did however have a number of serious flaws. Reduction in fetal movements is a very common symptom, with as many as 15 per cent of pregnant women presenting with it.[40] Although the conclusions of prospective trials of 'kick charts' have been challenged,[41] there is still no convincing evidence that routine use of fetal movement charting improves pregnancy outcomes.[40] While the jury is probably still out, it remains important to encourage women to report abnormal patterns of fetal movement early and to undertake assessment without delay.

Delivery

Women will very commonly request early delivery in pregnancies that follow unexplained stillbirth[12] and data suggest that many obstetricians accede to such requests.[28] The risk of stillbirth, using undelivered fetuses as a denominator, increases almost exponentially after 39 weeks gestation.[42] Obviously, should surveillance detect adverse fetal status then management and timing of delivery must be individualised. The great majority of pregnancies after an unexplained stillbirth will be uncomplicated. Many authors concede that the single most important aspect of management of uncomplicated pregnancies after an unexplained stillbirth may be early delivery, perhaps by 39 weeks.[3,4,6] When delivery is delayed beyond this gestation, prudence demands careful surveillance, probably with an ultrasound examination to estimate amniotic fluid volume and umbilical artery flow. Only a small number of women will request elective caesarean delivery in this setting, unless they have had a previous caesarean or were advised at the time of the stillbirth to have a caesarean birth in their next pregnancy.[12]

Research is needed

The few studies that guide management in pregnancies after unexplained stillbirth leave many questions unanswered and there is thus an urgent need for a large prospective study in this setting. Because unexplained stillbirth is a relatively uncommon outcome (there are about 2000 such losses each year in Australia), and because late fetal death is so traumatic, it is unlikely that randomised controlled trials of antenatal management will ever be undertaken.

Conclusion

Everyone involved in the care of a couple who have had an unexplained late fetal death find it distressing and challenging. Many couples will try to become pregnant again, and will seek guidance on the risks they face and whether anything can be done differently the next time. Careful surveillance and early delivery play an important role in optimising the outcome, although with the consequence that some adverse outcomes (low birthweight, preterm delivery, emergency caesarean section and post-partum haemorrhage) are likely to result from these interventions. It is critical that women and their families are provided with reassurance and support.

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CORRECTION TO DIPLOMATES WOMEN'S REPRODUCTIVE HEALTH REQUIREMENTS FOR THE 2008–2010 TRIENNIUM

Holders of the DRANZCOG and DRANZCOG Advanced with a certificate end date of 31 December 2010 have recertification requirements. In the current triennium, Diplomates must remain financial members of RANZCOG and obtain points in the area of Women's Reproductive Health as follows:

Diplomates who are Fellows of, or vocationally registered with the RACGP:

Women's Health requirements for 2008-2010 in the RACGP QA&CPD Program are a total of 40 points (one Category 1 activity) in Women's Reproductive Health activities.

Diplomates who are Fellows of, or vocationally registered with ACRRM:

Women's Health requirements for 2008-2010 in the ACRRM PD Program are 40 points in Women's Reproductive Health activities from the extended skills mandatory category (excluding ACRRM Teaching Practice Accreditation).

Diplomates who are NOT Fellows of, or vocationally registered with the RACGP or ACRRM:

Women's Health requirements for 2008-2010 are a total of 40 points (one Category 1 activity) in Women's Reproductive Health activities.

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A holistic approach to the care of parents experiencing perinatal death

'Our present society is not willing to experience death, in the sense that it is hidden by a conspiracy of silence. The sudden and unexplained death of a baby is very tragic, yet it is not regarded as something to be sad over, especially if the baby has never lived. As a consequence, parents are often not given permission by family or friends to mourn the death of their baby, and they are very often left alone in an apparently unsympathetic world, not knowing how to feel and not knowing how to cope.'

(Kubler Ross, 1986)[1]

Robyn Kelleher OAM
Social Worker

Holistic care of families experiencing perinatal grief is part of a marked improvement underway in health practices surrounding stillbirth and infant death. As prenatal testing becomes increasingly sophisticated and routine, more parents are learning devastating news before their babies are born. Although there is an option to terminate the pregnancy in these early stages, there are parents who will wish to continue the pregnancy despite the devastating outcome. Holistic care encourages parents to make the decision that is ultimately best for them. If they choose to continue with the pregnancy and providing that there are no risks to the mother's health, then every effort should be made to support the parents' decision.

Holistic care supports that the staff involved with parents' care should provide consistent, honest and comprehensible information from the the time of initial detection of problems and allow for questions as the reality of the information is processed by the parents. Holistic care encourages that strong consideration be given to offering the parents nonjudgmental, emotional support, rather than offering sedation.

Providing holistic care for parents through a perinatal loss contributes to a high standard of healthcare, as well as contributing to a normal grieving process. The role of the caregiver extends far beyond covering the physiological needs of the infant and starts at first contact with the parents. By creating an atmosphere of trust between parents and caregivers and a sense of attachment and bonding with the baby, a partnership will be formed between parents and caregivers, which should result in the most appropriate recommendations and decisions for that particular family.

In a holistic approach to perinatal grief management, a multidisciplinary team approach is recommended, including doctors, midwives, social workers and spiritual support, to care for the family before, during and after birth. The holistic care approach to perinatal loss supports families from the time of diagnosis, when their grief journey begins, through to a point where parents are able to manage the grief and loss of their baby within their own social networks.

The death of a baby is a profound loss and it is important and advantageous to acknowledge a family's need to grieve for their baby. The death of a baby is particularly difficult to endure because parents envision an entire lifetime for their baby from the time of confirmation of the pregnancy and because their expectations and vision have been built over time. With the death of their baby, parents lose an entire future. Parents also grieve for the loss of their own parenthood. Perinatal death represents multiple losses to parents, including the loss of a significant person, the loss of some aspect of self, the loss of external objects, the loss of a stage of life, the loss of a dream and the loss of creation. Culturally, a couple whose first pregnancy ends in a loss has not completed the rite of passage into parenthood, which symbolises adult status.[2]

'With the loss of unborn babies in the early stages of pregnancy, it is often perceived that there is no dramatic absence to signal the loss, causing the parents to have difficulty internalising the fact that the death has really occurred.'

The grieving process for parents can become complicated when the loss of a baby occurs in the very early stages of the pregnancy. There is frequently a social negation of the loss, particularly if the loss occurs in the first trimester of the pregnancy. It is often not recognised as a 'real death' because the baby would not have survived outside the womb. With the loss of unborn babies in the early stages of pregnancy, it is often perceived that there is no dramatic absence to signal the loss, causing the parents to have difficulty internalising the fact that the death has really occurred. 'Recollecting and re-experiencing the deceased and the relationship is made more difficult for bereaved parents because there is little or nothing concrete to review or remember realistically.'[3]

Factors which have been reported to increase the risk of adverse psychological outcome for parents after perinatal death include: perceived inadequate social support; traumatic circumstances surrounding the death; difficulties coping with a crisis in the past; problematic relationships in the nuclear family; and the presence of other life crises. In addition, generally, mothers report greater distress than do fathers.[4]

Care provided by professionals to parents before the birth of the baby and care provided to help the parents realise their loss is markedly different to the type of care that is needed after the loss. Following the birth of the baby, social workers and spiritual support workers can often provide families with the support they need to

facilitate the grieving process. Parents need to spend time with their baby and honour their cultural and religious beliefs.

Social workers and nurses often have the delicate task of collecting mementos for the parents: photographs, hand and footprints in either ink or plaster, locks of hair if possible, the baby's identification bracelet and the cot identification card. Cot identification cards and identification bracelets can be made for babies who are born in the very early stages of pregnancy, as this validates the baby's existence for the parents in the months ahead.

Holistic care highly recommends that continuity of care is provided to parents. Having the same professionals involved with the parents throughout their involvement within the health system, means that parents are able to develop a bond and rapport with those professionals and avoid retelling their 'story'. Continuity of care also ensures that parents are not given conflicting information.

Caregivers who provide this level of care will fulfill the unique needs of grieving parents by assisting them to have positive memories of their baby and by giving them a feeling of being cared for in the midst of their pain and grief.

Grief is a normal and natural response to loss. While research demonstrates that, generally, grief dissipates over time, providing quality holistic care before, during and after the loss of a baby greatly assists in the parents' recovery.

'We walk with families through pregnancy, birth, life and bereavement – supporting the dignity and value of each life.'[6]

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Maternal mortality in Papua New Guinea

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Most Australian health professionals are aware that health indicators for Indigenous Australians are much worse than national averages. Indeed, there have been regular ABC televised programs on the subject during 2008. However, just north of Cape York Peninsula and literally only a few metres from Queensland, health issues are much worse than most Australian health professionals could even imagine.

It is an accident of history, based somewhere in the meanderings of Captain Cook and other 17th and 18th century maritime explorers, that the current border of Australia passes through the narrow stretch of water that we call the Torres Strait. One can actually see Papua New Guinea (PNG) from the northern most islands of the Torres Strait.

The public health parameter that shows the widest discrepancy between developed and resource poor countries is the maternal mortality ratio (MMR). This is the number of women who die (per year) from pregnancy-related causes per 100,000 live births.

The MMR in Australia has been less than 10/100,000 for the past several decades. In fact, recently, it is has been mooted that, because hardly any women die from maternal deaths anymore, that the committee which was set up after the Second World War to annually examine maternal deaths and produce a triennial report to the Government, be disbanded because of insufficient activity. On the other hand, the MMR in Papua New Guinea runs into the hundreds. The MMR for Indigenous Australians usually runs at about two to three times that for non-Indigenous Australians, therefore 20/100,000.

'...the relative risk of dying from pregnancy-related issues is 500 times more likely in PNG than it is in Australia.'

In 1996, a demographic health survey (DHS) calculated the MMR in PNG to be 370 and the latest DHS (2006) has found it to have increased to 733. In the 1970s and 1980s, the World Health Organization (WHO) drew up a mathematical model to assist developing countries in working out what their MMR might be. It is notoriously difficult to accurately measure the MMR in a country that does not have quality vital registration systems. The figure that the WHO MMR predictive model calculated for PNG was 900!

These sorts of figures mean that a young woman in PNG has to consider that her lifetime risk of dying from a pregnancy-related cause is about one in 20, whereas the lifetime risk of an Australian woman dying from a pregnancy-related cause is probably about one in 10,000 (for Indigenous Australian women about one in 2000). Therefore, the relative risk of dying from pregnancy-related issues is 500 times more likely in PNG than it is in Australia (see Table 1). The PNG figures make for a completely different attitude towards pregnancy and risk in the minds of ordinary people. In Australia, most women would not even consider it a possibility that they could die from a pregnancy complication, whereas in PNG, every woman knows someone who has died from a pregnancy-related problem. In every class of school girls, there will be at least two who will die from a pregnancy-related cause during their lifetimes.

The demographic perspective for doctors and midwives is also quite different. Most doctors and midwives in Australia would not expect to see a maternal death in their whole professional life. Whereas in PNG, in a busy maternity unit (like that of the Port Moresby General Hospital where we have about 12,000 births per year), we can expect to see a maternal death once or twice a month. Thus, medical students and residents see several maternal deaths during their training period. Indeed, in the compulsory four-month O and G intern block, a resident could expect to see eight maternal deaths.

Table 1.

MMRs and lifetime risk of dying from pregnancy-related causes in Papua New Guinea and Australia.

	Australia	Indigenous Australia	Papua New Guinea	Typical MMRs from Africa
MMR	7-8/100,000	20/100,000	700-900/100,000	300-900/100,000
Lifetime risk of dying from pregnancy	1:10,000	1:2000	1:20	1:18-1:50

Why is it that so many women die from pregnancy-related causes in developing countries?

The MMR is not only the public health parameter that indicates the most discrepancy between developed and developing countries, it is also the most sensitive indicator of the quality and total functionality of the healthcare system of a country, as well as the socio-economic status of the community in a global sense.

For example, infant mortality rates (IMRs) in developing countries typically range between 40 and 90/1000 children for the first year of life. Developed countries typically have IMR figures of the magnitude of 10 to 20/1000. The IMR difference between countries like Australia and PNG is about five times (compared to 5000

times for the MMR difference). This is because simple public health measures (such as immunisation, exclusive breastfeeding, water, sanitation and primary healthcare access for illness treatment) can keep the majority of babies safe and healthy. Parents will take their sick children to the best facility that they can access when problems arise, even if this requires quite extensive travelling away from home. Babies are also quite portable.

Pregnancy care, on the other hand (particularly when it comes to complications that can kill), requires emergency obstetric care capacity and community infrastructure access (roads, bridges and vehicles) to get the woman to the emergency care facilty. Pregnant women are not so portable, particularly when they are in labour or bleeding postpartum. Time is also of the essence. A woman with a serious pregnancy complication (for example, postpartum haemorrhage or a ruptured uterus) can die within the hour.

Actual risk is also related to how many times you 'run the risk'. In Australia today, the total fertility rate (TFR), therefore, the total number of children a woman has in a lifetime is 1.8, whereas in PNG the TFR is over four. So it is much more dangerous for women to have a pregnancy in PNG and they are running the risk more than twice as often as Australian women.

The maternity care situation in Papua New Guinea

Most women do attend some kind of antenatal care (nationally about 60 per cent of women book at an antenatal clinic) at least once during their pregnancy, but many rural clinics are not able to do tests or provide detailed checks, nor are they are able to easily refer women when a problem is discovered. Only 38 per cent of women in PNG have a professionally supervised birth. This means that 62 per cent of women have their baby at home with only their mother or another female relative to care for them. A significant proportion of women (ten per cent) deliver their baby absolutely alone.

Recycling of hospital gloves – washed gloves drying on window panes.

Professionally supervised birth with expeditious access to emergency obstetric care is the single most important way of preventing women from dying with pregnancy-related complications. In PNG, this necessarily means having your baby in one of the better health facilities, where there is the realistic possibility of referral to a provincial hospital if something goes wrong.

In a study done in the mostly rural Simbu province in 1983[1], it was found that the MMR amongst women who had a village birth was 400. The MMR for women who had a facility supervised birth was 100.

The other thing that will make all the difference to the appalling maternal mortality situation in PNG is the demographic transition. In my professional career, the TFR has come down from six (1968), to 4.8 (1996) to 4.4 today. However, because of a major and long-standing epidemic of sexually transmitted infections in PNG, pelvic inflammatory disease is the commonest gynaecological problem that we see in clinics and of course this is associated with a high level of infertility due to tubal factors. This means that the average TFR of women who are not infertile is still nearly five. Our demographic health survey also shows that, by and large, women have one more baby than their ideal or desired family size. Unplanned high parity pregnancies are one of the major associations with maternal death in PNG. Family planning not only has social and economic benefits for most families in PNG, it can also be life-saving.

Effects on families, health workers, politicians and policy makers

The effect on a family is of course devastating. Older women with many children leave a number of children with no mother. These children are often distributed amongst relatives to look after, particularly if they are young. Older children may stay with their father. However, young primigravidas can be forgotten quite quickly. Men usually remarry after a few years and the children of the mother who has died can then be even more socially displaced. In developing countries, there are often no special counselling facilities available to assist health workers who have had to cope with a maternal death. At Port Moresby General Hospital, there is always a detailed audit process and junior staff are helped to understand about what we could not have done any better and those aspects of care which we could have done better.

Unfortunately, politicians and policy makers have yet to come to grips with this issue.

A young woman dies

The first maternal death this year at Port Moresby General Hospital was a young woman having her third baby. The first baby had been delivered by caesarean section (CS) when she had a persistent breech presentation at term. In the second confinement, she failed 'the trial of scar' and a repeat CS was performed. In this pregnancy, an elective CS was booked at term, but she came into labour on the Sunday morning before her booked operation. She was taken for a repeat CS by a senior registrar. Some four hours after the operation, she was found to have dropped in blood pressure and the duty consultant considered that there was blood in the peritoneal cavity. She was resuscitated with IV normal saline, but there was no blood of her type available in the blood bank. On return to theatre, she

was given a general anaesthetic by the duty anaesthetic registrar because of the emergency situation, but she had a bad chest and there was difficulty with oxygen saturations. She had a cardiac arrest in the recovery area and died a few days later from a combination of renal and respiratory failure.

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Transport issues present particular difficulties, especially in emergency obstetrics situations.

Training the local workforce to deal with emergencies in obstetrics is vital for saving lives.

Providing care at the very end of life

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It is an inescapable reality that eventually life will end in death and at some point all doctors will be required to provide care for a dying person. To adequately provide care, doctors must be able to recognise that death is imminent, to communicate this to other professionals and lay people, and if necessary, provide care to ensure the dying person's comfort, without imposing unnecessary burdens.

Care of a dying person

Paradoxes may confront doctors when caring for dying people. Modern medicine concentrates on achieving cures through diagnostic and therapeutic interventions, with death viewed as an implicit failure of the doctor's care. New problems or changes in a person's health usually prompt more investigations and treatments, which may not only be futile, but burdensome for the person. The optimal approach at the very end of life may be to exercise clinical judgements, relying on excellent bedside clinical assessments, providing meticulous pain and other symptom control through the most non-invasive means, whilst concurrently considering the emotional and existential issues of the dying person and those around them.[1]

Diagnosing dying

At any point in disease trajectories, the best care is delivered when the correct diagnosis is known and care of a dying person is no different. Clinical features that suggest death is imminent have been summarised and include:

- changes in functional state, where the person becomes increasingly more frail and entirely bed-bound in the last hours or days of life;
- fluctuating levels of consciousness; and
- an inability to take oral fluid, food or medications.

In the last hours of life, other changes which commonly occur include:

- altered respiratory patterns with marked mandibular movements;
- noisy, gurgling respirations sometimes called the 'death rattles' and;
- Changes to the peripheral circulation, with decreased pulse pressure and acrocyanosis.

There are wide variations in the changes observed in individuals and the timeframes over which such changes may develop.[2]

Symptom control at the end of life

Some people may develop symptoms that appear to be distressing at the very end of life. The most common problems observed by professional and lay caregivers include pain, dyspnea and respiratory secretions, agitation and confusion, dry mouth and continence. Of these, pain, respiratory changes and agitation are the most likely to concern relatives. Clinicians need to be cognisant of the fact that these problems may arise and have plans in place that may be readily implemented should these problems arise. There is little evidence to describe what the dying person's experiences of these symptoms might be. However, interventions are still given, as the little evidence that is available supports better outcomes for bereaved relatives when attention to symptoms perceived to be distressing is given.[3]

Management of specific symptoms

Pain is a common and feared problem for people with advanced cancer and other terminal diseases. There is no doubt that pain accompanies terminal illness, but pain that continues to crescendo upwards in the last hours of life is uncommon. Paradoxically, co-existing with the reality of pain is the fear that appropriately treating pain with opioid analgesia may hasten death. However, there is no evidence to support this[4] and many clinicians have concerns that the opposite is more likely.

All people in the terminal phase of life must have access to pain relief should they require it. At this stage, the medications most likely to be used are opioid analgesics, with the preferred route of administration being the subcutaneous route, though in some people, topical or intravenous opioid analgesia may be effective. Opioid naïve patients may only require low doses, such as morphine 2 mg fourth hourly. Others who have been previously taking opioid analgesia require conversion of the oral medication to either the subcutaneous or topical route of administration, using accepted opioid conversion tables. Excellent published guidelines are readily available to assist clinicians in safe and reliable prescribing at this stage of life.[5,6,7]

Agitation or confusion occurs commonly at the end of life, probably representing as delirium in up to 80 per cent of people. Terminal delirium may be hypoactive or hyperactive and is commonly associated with hallucinations and delusions that may or may not be distressing to the dying person and those around them. The decision to intervene must be based on a clinical assessment of how distressing or harmful the confusional state is to the person and those around them. Even though life is short, consideration of easily reversible factors must be given, although invasive investigations are probably best avoided. Non-pharmacological management of terminal delirium is often ignored, but should be considered as other situations may modify distress without causing further harm. A thorough physical examination to exclude urinary retention or faecal impaction as easily reversible causes of agitation is strongly recommended.

Following this, mostly, the management of terminal delirium focuses on prescribing antipsychotic medications, such as haloperidol and chlorpromazine, with benzodiazepines commonly as adjuvants in terminal care when people are very agitated or restless.[8] However, the evidence for any of these interventions remains limited and further research is needed.

'There is little evidence to describe what the dying person's experiences of symptoms might be. However, interventions are still given, as the little evidence that is available supports better outcomes for bereaved relatives when attention to symptoms perceived to be distressing is given.[3]'

Respiratory changes are common at the very end of life and include altered breathing patterns and the development of noisy respirations. The underlying pathophysiology that accounts for the changes in the patterns of respiration is not known, but is likely to reflect significant underlying metabolic changes associated with dying. Changes in the patterns of respiration are often accompanied by gurgling respirations that are sometimes known as the 'death rattles'. Again the aetiology of these noises is not well understood but probably reflects loss of gag and cough reflexes. It is likely that other secondary changes of airway narrowing contribute as well.

The evidence-based management of dyspnea in palliative care is improving and it is reasonable to extrapolate that even in the very final stages of life, subcutaneous morphine may alleviate the distress of breathlessness. This is in contrast to the management of noisy secretions. So far, none of the agents in common use have been proven to reliably reduce the noises. Despite this, accepted management remains that if the noises are proving very distressing to the person or those around them, interventions both pharmacological and non-pharmacological are indicated. Non-pharmacological intervention includes reducing parenteral fluids, positioning changes and gentle oropharyngeal suctioning. Pharmacological interventions include the subcutaneous administration of agents such as hyoscine or glycopyrrolate.[9]

A dry mouth is common at the end of life. This may be a source of distress for families and carers who see this as a symbol of the person starving to death. There are numerous reasons for a dry mouth and these include mouth breathing, decreased ability to manage oral fluids and hygiene, and anticholinergic effects of medications. The appearance of a dry and caked mouth may lead families to request parenteral hydration. However, the current literature would not suggest that this is likely to improve this problem. The best approach to this may be to discuss the problem with families and caregivers and to recommend regular mouth care. The best agent is not clear, but alcohol containing preparations are best avoided.

Conclusion

The most effective approach to terminal care requires acknowledgment and agreement that death is imminent in the terminally ill person. This is imperative to allow the delivery of the most competent and compassionate care, not only to the dying person, but to those around them.

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Childbed fever

A major cause of maternal mortality

Prof Caroline de Costa
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'Childbed fever' – puerperal sepsis due to streptococcal infection introduced into the vagina by a woman's birth attendants – was a common cause of death much feared by pregnant women until the end of the 19th century.

While fatal childbirth-related septicaemia is now extremely rare in current Australian practice, this is largely because of our armamentarium of powerful antibiotics. We would be wise to pay more attention, in the birth suites of the 21st century, to the basic principles of antisepsis and hygiene, elucidated by Semmelweis, Wendell Holmes, Lister and others in the 19th century.

Henry VIII had six wives but only one gave him a son. It was Lady Jane Seymour, the third wife, who fulfilled that most important duty for a queen of the times. However, she did not savour her triumph long, dying just 12 days after a prolonged labour and a difficult birth.

'...death from puerperal sepsis was relatively uncommon in ancient and medieval times, since women generally gave birth at home.'

Jane was first noticed by the King while serving as lady-in-waiting to the ill-fated Anne Boleyn, who had provided only a daughter, the future Elizabeth I, for Henry. Within 24 hours of Anne's execution, in May of 1536, Jane and Henry were formally betrothed, and were married four days later. (It was said that the puddings for the wedding feast were boiling even as Anne was led to the scaffold). Rumours of pregnancy began almost immediately, but it wasn't until early 1537 that the rumours were confirmed as fact, and the news of Jane's quickening celebrated throughout England. The Queen took to her chambers at Hampton Court in mid-September and began labour on 11 October. The following day, when she was still undelivered, her attending physicians asked Henry whether he wished the mother or the child to be saved. 'If you cannot save both, at least let the child live,' was Henry's prompt reply, 'for other wives are easily found.'

A few hours afterwards, Jane was safely delivered of a prince who was to have a short reign as Edward VI. The birth of his long-desired heir so excited the King that, overlooking the exhausted state of his Queen, he ordered the christening, in which Jane was required to take part, to be carried out within days. Jane, very weak, was wrapped in robes and carried to the prolonged ceremony on a litter. Only a day later, it was reported that she was gravely ill. She was delirious and had a high fever. Her doctors bled her but she never rallied and died 12 days postpartum from what was almost certainly puerperal sepsis, probably related to vaginal examinations performed by her physicians during her prolonged labour.

Puerperal sepsis has been recognised since ancient times as a killer of women following childbirth, the condition not heeding the social status of the mother. The writings of Hippocrates include references to childbed fever and there are even earlier references in some Hindu texts. It also seems that some of these ancient writers understood the potential for infection to be introduced by the birth attendants. The work of the Greek physician Soranus contains advice on cleanliness for midwives, as do the Hindu texts. It appears, though, that death from puerperal sepsis was relatively uncommon in ancient and medieval times, since women generally gave birth at home.

The 17th century saw the establishment of 'lying-in' hospitals throughout Europe, a development followed later in North America, Australia and New Zealand. These institutions were undoubtedly beneficial to some women in obstructed labour or with malpresentations, who could be delivered with forceps or by obstetric manipulations. However, overcrowding in dirty wards, as well as the complete lack of knowledge of the existence of bacteria and the need for antisepsis, meant that frequent vaginal examinations in labour and the use of unsterile instruments caused epidemics of puerperal sepsis throughout the ensuing two centuries. Between epidemics intermittent cases were common. It was well recognised among the medical profession and the public that the condition was peculiar to women giving birth: William Harvey wrote in 1651 that in postpartum women '...a suddaine gangrene doth induce a certain death'. Theories as to its causation were numerous and bizarre: that it was due to a 'miasma' circulating in the hospital, or to the troubled state of mind of the labouring woman, or to undue pressure of the uterus on the abdominal contents. The possibility of contagion as a cause was suspected by several doctors in Britain in the late 18th and early 19th centuries, among them Thomas Watson of King's College London, and Alexander Gordon of Aberdeen, who noted similarities between puerperal fever and erisypelas. However, little attention was paid by the profession as a whole to these observations.

Credit for discovering the infectious nature of the condition and for instituting measures to prevent it, goes to two remarkable men, Oliver Wendell Holmes of Boston and Ignaz Semmelweis, a Hungarian practising in Vienna. The two men worked independently, neither aware of the other's findings. Holmes' attention to the condition began in the early 1840s when two fatal cases of septicaemia, in a doctor and a medical student, were presented to his Boston Society for Medical Improvement. The doctor and student had both attended an autopsy of a woman who had died from puerperal fever. Holmes read all he could lay his hands on about the condition and became convinced that doctors, nurses and midwives were the agents of its spread. In 1843, he published his important short paper, *The Contagiousness of Puerperal Fever*,

which contained eight important rules for birth attendants, including such revolutionary advice as handwashing before attending a woman in labour and not going directly from the autopsy room to the bedside. He began to speak in public on the subject. For his pains, he was ridiculed by many of his colleagues. Prominent American obstetrician, Charles Meigs, was outraged at the suggestion that he might be infecting his own patients. 'Doctors,' he said, 'are gentlemen and gentlemen's hands are clean.'

'...given that overuse of antibiotics has led to widespread resistance by many other bacterial strains, we would be well advised to pay more attention during childbirth to the principles of "Listerism" in order to prevent a return to "the terror of the lying-in hospitals".'

At the same time, Semmelweis, assistant lecturer in the First Obstetric Division of the Vienna Lying-In Hospital, was developing what would become a life-long obsession with the disease. He was shocked by the high mortality rates among women giving birth in his division, which was where medical students undertook their obstetric training. In the years from 1841 to 1843, 16 per cent of all women giving birth at this hospital died from puerperal sepsis. In the Second Division, where midwives and midwifery students performed the deliveries, mortality from puerperal sepsis was only two per cent. Semmelweis observed that the medical students attended autopsies each morning before coming to his wards, whereas the midwives were not required to do so. However, it was only in 1847, when a pathologist colleague died of septicaemia, having accidentally sustained a cut to his hand during an autopsy, that Semmelweis made the connection between the soiled hands of students and doctors and the development of puerperal fever in women subsequently examined by them. Semmelweis established a system of cleaning hands for all those working in the First Division, using chlorate of lime solution, with remarkable success. In a six-month period in 1847, the death rate in the First Division plummeted from 18 per cent to two per cent of all women. Like Holmes, Semmelweis found scepticism and scorn among his colleagues. His contract in Vienna was not renewed and he returned to Hungary. He did not publish his findings and conclusions until 1861, when they were largely dismissed by the European medical establishment, and he died, depressed and bitter, in an asylum in 1865.

However, 1865 was also the year in which Joseph Lister began to apply principles of antisepsis to the practice of surgery in his wards in Edinburgh. Lister was impressed by the work of Louis Pasteur in France on the germ theory of disease. Insisting on scrupulous attention to hygiene during and following surgical procedures, Lister demonstrated a dramatic fall in death rates post-operatively. He too met disbelief and incredulity amongst many of his colleagues. 'Listerism' became a creed that doctors did or did not believe in, rather than a piece of scientific evidence. It took nearly 30 years for the profession as a whole to recognise the important truth of Lister's work. By the beginning of the 20th century, however, the use of sterilised instruments and dressings and meticulous attention to antisepsis during procedures were accepted features of obstetric as well as surgical practice. The use of rubber gloves for surgery and obstetrics, introduced in 1890, was the idea of Johns Hopkins Hospital surgeon William Halsted, whose scrub nurse (whom he later married) complained about the dermatitis she suffered from scrubbing with phenol. Halsted too, initially faced opposition from surgeons who complained that the gloves interfered with their surgical competence.

Nevertheless, deaths from puerperal sepsis continued, although in much smaller numbers than during previous centuries. It seems that the principles of Listerism were not universally applied. A variety of organisms (normal inhabitants of the skin, vagina and bowel) were responsible, but that most feared was the Group A haemolytic streptococcus, undoubtedly the cause of most of the institutional epidemics of earlier years. In 1935, in Germany, Gerhard Domagk demonstrated the prevention of streptococcal septicaemia in mice using prontosil, a sulphonamide dye. A year later, Leonard Colebrook and Meave Kenny at Queen Charlotte's Hospital in London reported in *The Lancet* their success in treating established puerperal sepsis using prontosil – the death rate dropped from 27 per cent of cases to eight per cent. Prontosil and other sulphonamides were followed by the introduction of penicillin in 1944, to which the streptococci causing puerperal sepsis remain sensitive.

The scourge of 'childbirth fever' epidemics has virtually disappeared from the maternity wards of developed countries. The maternal mortality rate in Australia has fallen from around 600 per 100,000 births in the year 1900 to 10 to 12 per 100,000 today – about two-fifths of this drop can be attributed to the prevention of deaths from infection. It is worth noting, however, that powerful antibiotics of all kinds are widely used in current obstetric and midwifery practice. Antibiotic prophylaxis is an intrinsic part of every caesarean section and antibiotics are routinely used for prolonged rupture of the membranes, many operative vaginal deliveries, and in virtually any woman developing a fever postpartum. This dependence on antibiotics, and the fact that few of us practising today in developed countries have seen a woman die from puerperal sepsis, has tended sometimes to produce a relaxed attitude to antisepsis in the birth suite. The Group A haemolytic streptococcus has decreased in virulence, probably due to the use of antibiotics, but also due to the introduction of better public health measures. However, given that overuse of antibiotics has led to widespread resistance by many other bacterial strains, we would be well advised to pay more attention during childbirth to the principles of 'Listerism' in order to prevent a return to 'the terror of the lying-in hospitals'.

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Dr Mercia Barnes

Dr Alastair Haslam
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Dr Mercia Barnes died suddenly aged 64, while operating at Waikato Hospital, New Zealand, on 13 April 1994. Resuscitation attempts were not successful and the procedure was completed by another surgeon. She had completed her term as President of the Royal New Zealand College of Obstetricians and Gynaecologists (RNZCOG) in February 1994.

Born in Raetihi, New Zealand, she was educated at Craighead in Timaru and the University of Otago Medical School, earning her BSc and later MBChB in 1955. She represented Otago and New Zealand universities at hockey and gained her 'Blue', a symbol of scholastic sporting achievement. Mercia's initial junior training was at Wairau Hospital in Blenheim. She also spent time doing orthopaedics at Cook Hospital, Gisborne. Her initial work in obstetrics and gynaecology was at St Helen's Hospital, Christchurch, and then at Waikato Hospital. She went to England as a ship's doctor. She worked at Elizabeth Garrett Anderson Hospital, and then at Caring Cross, Shoreham, and Chichester. Her MRCOG was taken in 1962. Mercia's obstetric long commentary was on hydatid disease in pregnancy, not well-known in England, despite the high number of dogs in the country. Her written paper asked candidates to compare the merits of forceps and the vacuum extractor. Indeed, Mercia acquired great skill and experience with the vacuum extractor.

Returning to Waikato in 1963 as a senior registrar, Mercia continued as locum obstetrician and gynaecologist. By the end of 1964, she was in a permanent position. She had considered missionary work in Africa, where her sister was teaching.

Inevitably, she became involved in College affairs, becoming Honorary Secretary of the New Zealand Council of the Royal College of Obstetricians and Gynaecologists (RCOG). This was the time of the creation of the New Zealand College and Mercia was the first Honorary Secretary of the New Zealand (later Royal) College of Obstetricians and Gynaecologists from February 1982. On completion of that term she joined the Boards of Education and Examiners.

Mercia had not sought high office, but was persuaded to be further involved with the College in the troubled early 1990s. She became President of RNZCOG in February 1991, continuing in that position until a few weeks before her death. This was a time of great change, particularly in maternity care, and some of the politics of the time saddened her.

Following Mercia's death, I was asked by the local newspaper whether surgeons should continue to work after reaching the age of sixty. I saw no reason why surgeon's shouldn't, with no signs of ill health, yet two of my senior colleagues died prematurely. It is a matter viewed differently as one ages. Mercia was involved in service throughout her working life. Her outside interests were in ornithology (the study of birds) and the church.

Dr Mercia Barnes, President, The Royal New Zealand College of Obstetricians and Gynaecologists (RNZCOG), 1991-1994.

Q&a

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

Q *A patient, aged 28, G2P1 at 31/40 gestation, presents to a small regional hospital with what appear to be contractions every five minutes. She had a normal vaginal delivery with her first baby at 38 weeks with no complications. She is otherwise well and a non-smoker.*

Dr Aimee Reilly
Registrar

a

This presentation is not uncommon and can present a conundrum for clinicians working in rural regions. The difficulty comes in making the decision regarding whether or not this patient is in preterm labour and whether or not she is at risk of delivery in the near future. If the cervix is 2 to 3 cm dilated, the decision is easy: proceed with antibiotic prophylaxis, steroid loading and tocolysis, and transfer to a tertiary centre. However, when the cervix is long and closed, with regular uterine activity, when should a patient be transferred to a tertiary centre for continuing care?

Initial assessment should begin with a full history, with particular focus on onset of, and length of contractions, presence of vaginal loss, and fetal movements. At this point, running through the general antenatal and personal medical and surgical history is warranted.

Initial examination should include abdominal palpation to determine presentation, along with timing of contractions. Baseline CTG will assist in assessment of fetal well-being. A speculum examination should be performed to view the cervix, with collection of preterm swabs and assessment for preterm premature rupture of the membranes (PPROM) with an amnicator. Use of fetal fibronectin testing at this point has become a useful part of the initial assessment process – a negative result can certainly aid in formulating a management plan.

Fibronectins are large glycoproteins found in the plasma and extracellular matrix. Fetal fibronectin is a unique fibronectin that has been identified in amniotic fluid, extracts of placental tissue and malignant cell lines. It is thought to be a 'trophoblast glue', promoting cellular adhesion at utero-placental and decidual-fetal interfaces. When the extracellular matrix of the chorionic/decidual interface is disrupted, it is released into cervicovaginal secretions. Fetal fibronectin is normally present in the cervicovaginal secretions prior to 22 weeks, thus testing in the first half of the pregnancy is not useful.

The collection process involves sampling from the secretions in the posterior fornix or external cervical os during a speculum examination, using a swab from the manufacturer's kit. Manipulation of the cervix (digital or ultrasound examination, coitus within 24 hours) and introduction of intravaginal lubricants or medications should be avoided pre-examination, as this can lead to a false positive or false negative result.

The value of testing for fetal fibronectin in symptomatic women has been demonstrated in a systematic review[1] including 40 prospective studies evaluating cervical and vaginal fetal fibronectin for predicting preterm delivery. A positive test was obtained in almost 80 per cent of women who went on to deliver within the next seven days. Iams *et al* concluded that the assay was superior to the usual clinical assessments for predicting preterm delivery in symptomatic women, such as digital cervical assessment.[2]

The high negative predictive value of fetal fibronectin proves to be the most beneficial aspect of the test, particularly in women with preterm contractions in whom the diagnosis of preterm labour is uncertain. In a study by Peaceman *et al*, 99.5 per cent of pregnant women who presented initially with signs and symptoms of preterm labour and who had a negative cervicovaginal test, failed to deliver within seven days.[3] In contrast, its high false positive rate makes it less than optimal for prediction of preterm delivery, but should still prompt consideration of administration of glucocorticoids to accelerate fetal lung maturation.

Initial blood work should include a complete blood count, C-reactive protein, along with a group and save, and urine culture. If available, ultrasound assessment to confirm presentation, liquor volume and cervical length (if possible) can be very useful for assisting in the decision-making process, but is not always a readily accessible option. Women with a cervical length of greater than 30 mm have been shown to be unlikely to deliver preterm.[4]

When the decision is made that a woman is at an increased risk of delivery within the next seven days, transfer to the nearest tertiary centre should be organised at the same time as the commencement of antibiotic prophylaxis with Benzylpenicillin IVI. Controlled trials have shown a reduction in maternal infection with the use of antibiotics (prophylactically) for preterm labour with intact membranes, but have shown no benefit in neonatal outcomes.[5] Of note, Oracle II concluded that some prophylactic antibiotics (amoxycillin + clavulanic acid) actually increase the rate of neonatal morbidity.[6]

In a gestation of less than 34 weeks, give betamethasone 11.4mg IM, then repeat in 24 hours. Corticosteroids are effective in preventing adverse perinatal outcomes, most notably respiratory distress syndrome, and in increasing the likelihood of neonatal survival.[7]

Consider tocolysis (even if 34 to 37 weeks gestation) using nifedipine 20 mg STAT (chewed), followed 30 minutes later by a repeat dose and three-hourly from thereon. There may be an indication for salbutamol infusion use for transfer of a woman in threatened preterm labour (TPL), however, there are numerous contraindications to consider, along with a side-effect profile that may prohibit its use. With respect to neonatal outcome, Tstatsaris *et al* showed that nifedipine appears to be more effective than beta-agonists for tocolysis and should be considered for use as a first-line tocolytic agent.[8]

If, however, delivery is imminent, the patient may need to be delivered at the rural centre, with a neonatal retrieval team organised early to retrieve the baby. This is a decision which can be made in conjunction with the obstetric and paediatric teams from the referral base. A delivery in a hospital with readily available neonatal resuscitation equipment is preferable to delivery in transit.

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All RANZCOG members are invited to submit questions, tips or interesting cases to *Q&a*.
Please send entries to *Q&a* @ *O&G* via:
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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
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Any enquiries please contact:
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The impact of the death of a practitioner on your practice

Miranda Gilberg
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Alicia Speer
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When a medical practitioner retires or relocates, it often takes some time to prepare for closure or sale of their medical practice. It is considerably more difficult where the unfortunate situation of a sudden death occurs, especially in a solo practice.

Regardless of the structure of your O and G practice, it is essential to understand some of the requirements that may come into play in an emergency situation, such as the death of a practitioner.

Wills and the estate

First and foremost, the legislative framework that takes effect upon the death of a person in relation to their estate provides the grounds for which all other aspects need to be considered. Initially, the practice, as a business owned by the deceased practitioner, passes to the estate of the practitioner (if a will does not state otherwise). Similarly, in a partnership or associateship arrangement, the ownership of that part of the business will pass along in the same manner (unless otherwise provided for within the applicable agreement).

In either of the above cases, the important first step is for the estate to consider the future of the practice or their part of the practice. Generally, a practice in this situation will be sold (though it may simply be closed instead), either as a whole entity where the deceased practitioner was the sole owner and also maintains ownership or contracts for the premises on which the practice is located, or bought out by other partners or associates. Such a decision necessitates the estate to consider a number of factors, including any known wishes of the deceased practitioner when making such a decision.

Informing the patients

Patients should be advised by either the estate or the incoming/existing practitioners as soon as practicable after the above decision has been made. It is important that this notification not only informs the patient of the future of the practice, but also the proposed handling of their medical records (discussed in detail below). This notification is ideally by direct contact (phone, email or letter), whatever is appropriate for your practice, but can be supplemented with advertisements in local newspapers or professional newsletters.

It is also prudent to contact all regular referring general practitioners so that they can be aware of the future situation for new patients. Notifications should also be made as soon as practicable to the Medical Board in your local State; Medicare Australia; the deceased practitioner's medical defence organisation; and any other professional or membership bodies such as RANZCOG.

There is no obligation on the estate or practice to refer the patients to another treating O and G where there are no continuing doctors in the practice. In fact, it would be advisable for the practice to avoid such referrals. Instead, practices can provide details of nearby O and G practices and provide patients with instructions to revisit their general practitioner for a new referral.

Handling of medical records

The ownership of the medical records retained by the practice will generally pass to the estate. However, this becomes complex where various state legislative provisions provide that only a medical practitioner shall retain records. There is no available case law that provides clarification on this situation, however, conservatively speaking, it would be ideal for the estate to maintain the records for the duration of time required by their state legislation.

'Without the medical record or medical practitioner, the defence of [medical negligence] cases would be near impossible.'

This can be a daunting proposal, as it generally involves the executors of the estate, often a family member, looking at storage, retention and potential recollection of thousands of medical records for up to 25 years. However, the importance of the retention is demonstrated in medical negligence cases, which can be run for many years after the birth. Without the medical record or medical practitioner, the defence of these cases would be near impossible.

Some alternate options that are available in relation to the medical record are for the new practitioner or existing practice structure to take over responsibility for the files. It may also be possible to provide all patients with their files or to pass these on to a new practitioner of the patient's choice. However, this also comes with a risk as stipulated above in relation to defence of malpractice cases. Without the medical record, the defence of these cases would be near impossible.

The estate may also consider use of a records repository where patient files are maintained and retrievable through an external facility, however, this will attract fees. With electronic records and scanning capabilities, records may also be maintained on disk or in data vaults (online secure data storage points) which can minimise costs, space and retrieval time.

'We strongly advise that any executor who is faced with executing an estate as the result of the death of a practitioner seek legal and/or other expert advice to ensure all legislative duties are complied with.'

Practice staff and equipment

If it is determined that a practice is not going to continue as a medical business after the death of a practitioner, consideration must also be given to staff and equipment. The responsibility for these considerations again falls to the estate.

In terms of staffing, ideally all staff will be informed of the practice closure as soon as possible. Where the minimum redundancy notice provisions cannot be adhered to, the staff are paid for this period in lieu of working. Additionally, all entitlements for leave that are outstanding must be paid out on termination. If the practice is being sold as an entire entity, including on-selling the staff, consideration must be given to their leave entitlements at the time of exchange, as these will transfer with the staff to be the responsibility of the new employer.

Medical equipment can be sold via a range of options including advertisement in medical magazines and journals or, in some instances, can be donated to disadvantaged countries.

Disposal of medications and prescription pads

Any medications or prescription pads that are left in the practice and cannot be used by another practitioner should be disposed of in accordance with local health department guidelines.

We strongly advise that any executor who is faced with executing an estate as the result of the death of a practitioner seek legal and/or other expert advice to ensure all legislative duties outlined above are complied with.

Letters to the Editor

A New Zealand response to the medico-legal article on elective caesareans, *O&G* Vol 10 No 4 Summer 2008; p48-49.

Elective caesarean section, when there is no medical justification, is becoming a more and more debated issue. *O&G Magazine's* Summer 2008 medico-legal opinion looked at this question and two Australian answers were published.

A New Zealand Fellow pointed out that perhaps, on such a controversial issue, we should also include a New Zealand opinion. The controversy of a 'maternal request' for caesarean section is accented in New Zealand, given that Section 88 is supposedly predicated around maternal choice. Whilst it may seem, at first consideration, that choice predominates in a clinical discussion of birth options, in reality, choice cannot exist in splendid isolation, nor can it overrule one's professional obligations to make recommendations based on a woman's best interests and a balance of risks versus benefits. Expressed simply, while any woman is free to express a preferred choice, so is a practitioner free to determine that they cannot, in good conscience, agree to that request in the absence of a clinical indication.

In Sue Belgrave's comprehensive and excellent article entitled 'Caesarean section' (*nzfp* Vol 30 No 4, August 2003), she includes discussion on this issue. Here she quotes the legal opinion that was sought in New Zealand on this issue in 2002. The opinion stated that, 'in the absence of any clinical reasons rendering caesarean delivery the preferred delivery method, it is our view that doctors and District Health Boards are entitled to and should decline to perform this procedure in favour of natural birthing options'. (Meredith Connell. *Elective caesareans without medical justification*. Letter to Aon Legal Buying Group, September 2002.)

This opinion has indeed been adopted in the public system by most District Health Boards in New Zealand and remains current.

Dr Sarah Tout
FRANZCOG

Denys Court
Medico-legal Consultant
Medical Protection Society (MPS)

Response to the edition on obesity, *O&G* Vol 10 No 4 Summer 2008.

Dear Editors,

The same day that I received your thought-provoking and timely edition focusing on obesity, I was doing a locum for a colleague. One of his antenatals was a 37-year-old primigravida at 37 weeks, of average height but weighing 162 kg. Not surprisingly, I had to admit her with pre-eclampsia. What alarmed me most about the case, however, was that she told me the pregnancy was the result of IVF. I asked her what her weight was when she had the embryo transfer. She replied 140 kg.

Come on, CREI supervisors, how about teaching your trainees some common sense. Apart from questioning the need for IVF in a woman of that BMI, spare a thought for the obstetrician who now has to carry the can and, most of all, the patient placed at iatrogenic risk.

Dr Graeme Dennerstein
FRANZCOG

Journal Club

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

Progress in non-invasive testing for chromosomal anomalies in early pregnancy

The ability to detect and measure fetal nucleic acids in maternal plasma has led researchers to look at the possibility of using these techniques to test for chromosomal abnormalities in early pregnancy, without risk to the fetus. An article from Hong Kong, in *BJOG*, reviews the progress to date in this field, which is still experimental. One approach is based on the measurement in maternal plasma of the allelic ratio of single nucleotide polymorphisms in the coding region of placental mRNA. A second approach is through the analysis of DNA fragments with different patterns of DNA methylation between fetal and maternal DNA. A third technique involves the enrichment of the fractional concentration of fetal DNA in maternal plasma using physical or chemical methods. Finally, say the authors, the development of more precise digital PCR-based methods for fetal nucleic acid analysis may contribute further to developments in this area. While the complex biochemistry may prove daunting to the busy obstetrician, the implications for clinical practice of a reliable non-invasive diagnostic test for chromosomal abnormalities are clear.

Lo YMD. Non-invasive prenatal detection of fetal chromosomal aneuploidies by maternal plasma nucleic acid analysis: a review of the current state of the art. *BJOG* Jan;116(2):152-7.

The complete guide to preconception care

In 2005, the US Centers for Disease Control established the Select Panel on Preconception Care to oversee working groups who would review and make recommendations on every important clinical aspect of the care of women planning pregnancy. Over two years, these groups focused on developing a 'clinical preconception care agenda'. The results are published in this supplement to the American Journal and deal comprehensively with this topic. The suggested components of preconception care include health promotion and the provision of health education that is individualised to a woman's or couple's needs, plus 'a thorough and systematic identification of risks potentially affecting future pregnancies and the initiation of actions to address such risks'. Numerous articles describe the clinical content of preconception risk assessment and management: immunisations, infectious disease screening, medical and psychiatric conditions, parental exposures, genetics and genomics, nutrition, environmental exposures, psychosocial stressors, medications and reproductive history! Finally, two articles cover particular populations and advice for preconception care for prospective fathers – very wide-ranging and up-to-date coverage of an aspect of care most of us would wish to see become an integral part of the practice of women's health.

Jack BW, *et al.* The clinical content of preconception care. *Am J Obstet Gynecol.* 199:6 Suppl B (December, 2008).

Treating partners of women with chlamydia

Like Australia, the UK has seen a dramatic rise in the number of cases of uncomplicated chlamydia over the past ten years, with a concurrent risk for women of pelvic inflammatory disease (PID), especially when infections recur. Treatment of patients is usually straightforward (a single dose of azithromycin), but getting appropriate treatment to partners in a timely manner can be difficult. Notification of partners with subsequent testing and treatment is the ideal course of action, but for a variety of reasons has been less than successful. Partners may need to wait several weeks for a clinic appointment during which time the patient is re-infected. 'Patient-delivered partner therapy' (PDPT) has proved more successful in other parts of the world. In *BJOG*, the authors of a study comparing the views of men and women attending sexual health and other clinics in Scotland found PDPT acceptable to women, while men, at least in theory, preferred clinical referral. The author of an accompanying commentary states that PDPT for treating partners of women with uncomplicated chlamydia is a realistic and inexpensive public health measure that should be widely available in the UK.

Melvin L, *et al.* Preferred strategies of men and women for managing chlamydial infection. *BJOG* 2009; 116(3):357-65.

Cameron ST. Patient-delivered partner therapy for chlamydia—a realistic public health measure in the UK. *BJOG* 2009; 116(3):345-46.

OTC pills for obesity – not such a good idea?

Around 50 per cent of obstetric and gynaecological patients are overweight or obese. The anti-obesity drug orlistat is now available over the counter (OTC) in Australia. Earlier this year, the European Union also approved its sale OTC. But, ask the editors of *The Lancet*, is this in the best interests of our patients? Orlistat is said to have only a limited success in the management of obesity, the average weight loss being merely 2.5 kg per year. 'Making this drug available OTC will add false credibility to the notion that there is an easy pill-popping solution to obesity rather than long-term lifestyle changes,' says *The Lancet*. As well, a lack of medical supervision means that overuse could lead to undiagnosed nutritional deficiencies. Evidence is urgently needed, say the editors, to demonstrate that OTC decisions are made that serve the long-term interests of the public.

Editorial. Over-the-counter medicines – in whose best interest? *The Lancet* 2009; 373(9661):354.

See page 54 for another review by Professor HP Dietz.

Book reviewed by HP Dietz
Sydney

Atlas of Urogynecological Endoscopy
Edited by Peter Dwyer

Informa Healthcare UK, London 2007.

Cystoscopy is one of those areas at the limits of our specialty's turf that has received little or no attention in textbooks of Obstetrics and Gynaecology. Peter Dwyer's book fills this niche in an admirably complete fashion. It is a testimony to the development of Urogynaecology worldwide that Informa Healthcare have decided to publish this substantial and very well produced atlas – and that it can be sold at a very reasonable price.

One of the most senior Urogynaecologists in Australia, Professor Dwyer has assembled an impressive team of contributors. The result is a book that, in 15 chapters, covers the subject comprehensively. Most useful to trainees is a detailed description of instrumentation and technique and an abundance of cystoscopic images showing normal variations in the appearance of urethra and bladder. On the other hand, the book presents a wealth of abnormality, and one finds comprehensive coverage of subjects such as congenital abnormalities, urethral diverticulae, urethritis, cystitis, bladder cancer and the painful bladder syndrome. I found the latter chapter particularly useful, seeing that it was authored by the foremost Australian expert on this subject, Dr Anna Rosamilia. The text is generally of a very high quality, concise, direct and to the point and very informative.

It would be unusual to find nothing to criticise in a publication as ambitious as this atlas, but I have only a few suggestions to make. The anatomy chapter would benefit from a discussion of areas of contention regarding urethral morphology, support and function, since there is widespread disagreement in the literature on all those issues. As continence is discussed in detail, the biomechanics of continence may deserve more attention. Text, figures and tables are occasionally duplicated in separate chapters. While in some instances this may be difficult to remedy, it should be possible to avoid using the same illustration twice. On another note, the subject of carcinoma in situ of the bladder may need more extensive treatment. Only time will tell whether the chapter on urogynaecological laparoscopy will be needed in future editions.

In summary, this well-produced and highly informative work will be an asset in every gynaecologist's office and hospital reference library, but is particularly useful to the trainee, especially those with an interest in urogynaecology, and of course to the subspecialist.

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) and follow the link to 'Update contact details' or call 03 9417 1699 to notify the College of your changed contact details.

MOET Australia

Dr Rahul Sen
FRANZCOG

The Managing Obstetric Emergencies and Trauma (MOET) course is a UK-based training and skills course for senior obstetricians and anaesthetists, that is widely regarded as the premier course of its kind in the UK. Some hospitals require MOET as a pre-requisite for hospital employment.

There is currently no course quite like it in Australia. Using a combination of skill drills, scenarios, moulage, demonstrations, group workshops and didactic teaching, candidates spend two days undergoing intensive teaching with continuous assessment. On the third day, candidates sit a multiple choice question (MCQ) exam and have to pass an objective structured clinical (OSCE) exam.

The top performing candidates are selected to be MOET instructors. They then attend a generic instructor course where they undergo further training on becoming an instructor, using modern educational theories.

The course is supported by a course manual, which is a stand-alone text and provides an excellent resource for obstetricians and obstetric registrars, especially those approaching their membership exams.

The course is coming to Australia in November 2009. We will be running a series of courses in Sydney as follows:

November 9-11 – MOET Course 1
November 13-15 – Generic Instructor Course
November 17-19 – MOET Course 2

We are looking for obstetricians and anaesthetists to enrol in the course and become the first wave of homegrown certified MOET instructors. We need senior clinicians who can commit to all three courses and to propagating MOET in Australia in the future. This course is ideally suited to directors of obstetrics and those who provide senior cover on delivery suites.

If you are interested in enrolling in the Sydney courses, please contact Jenny Antrobus at Advanced Life Support Group (ALSG) at: jantrobus@alsg.org .

For more information visit: www.moetaustralia.com.au .

Other contacts:

Rahul Sen (MOET Australia)
(e) rahulsen@doctors.org.uk

Jenny Antrobus (Advanced Life Support Group)
(e) jantrobus@alsg.org

Asia Pacific Committee

Involved in a developing country?
We'd love to hear from you!

The APC is keen to be kept informed about activities and involvement of our Fellows in all developing countries, but particularly the Asia Pacific region. From this information we will be able to increase valuable networks and build a more comprehensive picture of the involvement of College Fellows in the region, either under the auspices of the College or via other avenues or personal connections you may have.

Please send one paragraph outlining details of any activities/projects/consultations you have been involved in over the past year or details of activities you will be involved in for the coming year to:

Carmel Walker
Coordinator Asia Pacific Services
(e) cwalker@ranzcog.edu.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.ranzcog.edu.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.

College Statements Update
March 2009

Michael Permezel
FRANZCOG
Chair, Women's
Health Committee

Since last Council in November, the Women's Health Committee (WHC), have not passed any new statements. Several new statements are currently being finalised and will hopefully be ready for publication in the Winter edition of *O&G*.

New College Statements

• None available at present.

All statements are available on the College website at:
www.ranzcog.edu.au/publications/collegestatements.shtml

Revised College Statements

The following revised statement has been approved by the WHC and subsequently endorsed by Council. It is also available online at:
www.ranzcog.edu.au/womenshealth/statementsupdate.shtml

WPI-12: Guidelines for Locum Positions in Specialist Obstetric and Gynaecological Practice in Australia and New Zealand

Under the subheading *Responsibilities of Locum*, a minor amendment occurred. Point six was changed to read as follows (change in bold):

- **ensure that he/she has** a registered Provider Number for each location of employment.

Development of New Statements

Development of statements on the following is underway or continuing:

- Subgaleal Haemorrhage
- Progesterone in the First Trimester of Pregnancy
- Prophylactic Oophorectomy at the Time of Hysterectomy for Benign Conditions
- Robotic Assisted Surgery in Gynaecology

The next comprehensive update of College Statements will be published in the Winter edition of *O&G* in June 2009.

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

Council Meeting Report

November 2008

Penelope Griffiths
Manager
Executive Services and Human Resources

Introduction of new Councillors

The Honorary Secretary introduced the following new Councillors to the President. The President welcomed new Councillors to the Sixth RANZCOG Council:

- **Professor Ian Symonds**
  Councillor resident in New South Wales
- **Dr Alec Ekeroma**
  Councillor resident in New Zealand
- **Dr John Wilson**
  Councillor resident in Queensland
- **Dr Christopher Hughes**
  Councillor resident in South Australia/Northern Territory
- **Dr Lisa Begg**
  Councillor resident in Victoria
- **Associate Professor Susan Walker**
  Councillor resident in Victoria
- **Associate Professor Glyn Teale**
  Councillor representing Provincial Fellows

Report from the President

The President reported to Council on matters concerning:

- The Australian Federal Government's release of a discussion paper, *Improving Maternity Services in Australia*. Following input from College members and lengthy consultation by the Executive Committee, the College response to this review had been submitted on 31 October 2008.

- The appointment of the Director of Education had taken place in October 2008 and Mr Julian Cross had commenced at the College in October 2008.

- The Government is conducting a review of future funding for diagnostic imaging and pathology and RANZCOG has made a submission. A response from the Government is awaiting.

- Arrangements were discussed for AOCOG 2009/RANZCOG 2009 ASM, Auckland, New Zealand, 26-30 March 2009.

Report from the CEO

The CEO presented his report and spoke on the following matters:

- Interactions with governmental and other stakeholders on a range of factors relevant to College interests;

- Commencement of long-term College organisation restructure;

- Advice from the Australian Medical Council (AMC) confirming extension of accreditation of RANZCOG for a maximum of four years until December 2013, subject to the College continuing to submit satisfactory annual reports;

- AMC draft code of conduct for medical practitioners in Australia – consultation process underway; and

- Formation of the Conjoint Committee for the Diploma of Obstetrics and Gynaecology (CCDOG) to oversee the formulation of policy, development of curriculum and administration of the qualification DRANZCOG and DRANZCOG Advanced. AMOU has been signed by ACRRM, RACGP and RANZCOG to form this conjoint committee.

Report from the Executive Committee

Confidential information and Conflict of Interest

Two deeds of undertaking in relation to Confidential Information and Conflict of Interest and for Committee Members and RANZCOG Representatives on External Bodies were approved by the Executive Committee.

Conjoint Committee

A memorandum of understanding (MoU) between the Australian College of Rural and Remote Medicine (ACRRM), the Royal Australian College of General Practitioners (RACGP) and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) for the formation of the Conjoint Committee for the Diploma of Obstetrics and Gynaecology has been signed by all parties. This conjoint committee replaces the functions currently undertaken by the JCCO. A copy of the MoU and terms of reference were circulated.

As a result of the MoU, a joint committee on Women's Health will also be convened. This is to promote dialogue and cooperation between the senior office bearers and executives of the ACCRM, RACGP and RANZCOG in matters of mutual interest relating to the delivery of maternity services in Australia. The Terms of Reference had been circulated for information.

FACE Committee and Honorary Treasurer's Report

The Honorary Treasurer presented her circulated report covering the following areas of College finance:
- Investments
- Profit and Loss Account and Balance Sheet
- Unfinancial Fellows
- Credit card payment of subscriptions.

GP Obstetric Advisory Committee

Dr Jeff Taylor, Chairman of the GP Obstetric Advisory Committee (GPOAC) presented reports on the following items:

- Diplomates Recertification 2005-2007 triennium
- Diplomates Recertification 2008-2010 triennium

- Diplomates Days - XXIst AOFOG Congress (AOCOG)/2009 RANZCOG ASM, Auckland, New Zealand, 26-30 March 2009
- Diplomates Day - 2009 Provincial Fellows ASM, Cable Beach, Western Australia, 29-31 May 2009
- GP Obstetric Advisory (GPOA) Committee Elections
- Retiring Committee Members
- Specialist Obstetrician Locum Scheme (SOLS)
- RACGP 51st Annual Scientific Convention Melbourne, 1-5 October 2008
- ACRRM Scientific Forum and Rural Doctors Conference, 23-26 October 2008.

At the conclusion of Dr Taylor's report, the Honorary Secretary stated that GP obstetricians are the central part of Australia's rural workforce and it was vital that the College acknowledge this important contribution to the provision of O and G services in Australia.

The President thanked Dr Taylor for his outstanding contribution in progressing the work of the GPOAC and in promoting the role and significance of GP obstetrics.

Honours Committee

Council approved the awarding of an Honorary Fellowship to Professor Pak-Chung Ho.

Education and Assessment Committee

Award for Outstanding Achievement in MRANZCOG Oral Examination

Dr Sarah Elizabeth Machin (New Zealand) was awarded the RANZCOG Award for Outstanding Achievement in the MRANZCOG Oral Examination.

Award for Outstanding Achievement in DRANZCOG Oral Examination

Dr Linda Faye McKay (Western Australia) was awarded the RANZCOG Award for Outstanding Achievement in the DRANZCOG Oral Examination.

Membership of the Boards of Examiners

DRANZCOG

The following specialists were appointed to the DRANZCOG Board of Examiners:

- Dr Scott Finlay
- Dr Fali Langdana
- Dr Carolyn Miller
- Dr Lee Minuzzo
- Dr Gowrie Ratnavelar

MRANZCOG

The following specialists were appointed to the MRANZCOG Board of Examiners:

- Dr Dushyant Maharaj
- Dr Ian Page

CREI Subspecialty

The following subspecialist was appointed to the CREI Subspecialty Board of Examiners:

- Dr Anusch Yazdani

CMFM Subspecialty

The following subspecialist was appointed to the CMFM Subspecialty Board of Examiners:

- Dr Emma Parry

Amendment to Regulation 10.1.4

Council approved amendments to Regulation 10.1.4 as follows: [changes in bold]

Trainees who have completed all requirements for either Membership or Fellowship of the RANZCOG, except for satisfactory completion of the MRANZCOG Written and/or Oral Examination, and other stipulated requirements, must remain on the register and continue to occupy a prospectively approved post under supervision. These Trainees must pay the full annual training fee and participate in standard formative and summative assessment. **Trainees in breach of this regulation will not be permitted to sit the relevant examination/examinations.**

While recognising that the required 72 months of accredited training has already been completed by Trainees in this category, the College requires ongoing formative and summative assessments in order to provide the Trainees with regular formal feedback and to ensure remedial assistance is provided to them in the event that any deficiencies are identified during this period.

Trainees in this category must also remain within the current stipulated timeframes for completing Membership and Fellowship requirements.

Amendment to Regulation 7.1.5

Council approved amendments to Regulation 7.1.5 as follows [changes in bold]:

7.1.5 Failure to Complete a Required Component of the Training Program by the Specified Time

7.1.5.1 The six-monthly summative assessment report is the mechanism by which a failure to meet any training assessment requirements by the required time is dealt with. Such requirements include, but may not be limited to:

- Completion of a Basic Surgical Skills Workshop by the end of Year 1
- **Completion by the end of Year 1 of a Fetal Surveillance workshop or course which has recognition by the College**
- Attendance at a Communication Skills Workshop by the end of Year 2
- Completion of assessment of surgical skill in basic level procedures by the end of Year 2
- Attainment of prospective approval of a research project by the end of Year 3 (or attainment of an exemption based on prior research)
- Completion of assessment of surgical skills in advanced procedures by the end of Year 5.

Continuing Professional Development (CPD) Committee

Extraordinary meeting of the CPD Committee - Practice Review and Clinical Risk Management Issues

An Extraordinary meeting of the CPD Committee was held on Sunday, 20 July 2008, to discuss PR&CRM issues. The outcomes were as follows:

- It was agreed that a random sample of Fellows would be selected to trial the new program in 2009 and that these Fellows be given the choice to opt-out. If they opt-out of the program mid-stream, they will be asked for feedback as to their reasons and any suggestions they have for improvement to the program. It is important to have a cross-section of the Fellowship.
- The current program continues, using trial to work out 'what works and what doesn't'.
- PR&CRM points will be abolished for meetings/workshops that use pre and post MCQs to obtain PR&CRM points from 2010. Pre and post MCQs are to be discussed at the next CPD meeting.
- Trial a curriculum-based program, for example, the LEAP Framework. The submission of a Learning Plan to identify the Fellow's needs at the beginning of each CPD cycle, should be encouraged.
- There will be a three-year CPD period – a minimum of 150 hours, with 25 of these hours being in the area of PR&CRM, which includes an audit (plus an action plan) and a CRM activity from a list of approved CRM activities.
- Fellows should be given 12 months notice prior to the introduction of the new program.
- It was agreed that the CPD program requirements should be 150 CPD points or hours with 25 of these points/hours in the area of PR&CRM – they must include an Audit/Quality Cycle. (Changes to hours will mean a change to the point structure of College projects).

It was agreed that the Medical Council of New Zealand have guidelines that must be taken into consideration when restructuring the program.

Asia Pacific Committee

Information for volunteers about working in the Pacific

Council was advised that the Asia Pacific Committee had developed general information for prospective volunteers planning to visit the Pacific. The following were presented to the Executive Committee and were approved by the Executive to be made available on request and via the College website:

- Information for volunteers about working in the Pacific – Papua New Guinea
- Information for volunteers about working in the Pacific – Fiji.

Specialist Obstetrician Locum Scheme (SOLS)

In the Federal budget, SOLS funding was allocated for three years. However, the contracts with the Department of Health and Ageing will be one financial year at a time. The current contract extends from 1 October 2008 to 30 June 2009.

SOLS funding has been expanded to provide additional locums for specialists and locum cover to GP obstetricians. SOLS targets to have 80 locum placements for Fellows and ten locum placements for GPs, all to be completed prior to June 2009. SOLS is currently developing the criteria and application forms for GP locum placements, reviewing specialist application forms and preparing an evaluation plan.

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@ranzcog.edu.au

SOLS Update

Valerie Jenkins
Chair
SOLS Management Group

In July 2006, the Commonwealth funded RANZCOG to pilot a locum service for specialist obstetricians, called the Specialist Obstetrician Locum Scheme (SOLS). The pilot proved to be very successful and further funding was made available in October 2008. The new contract with the Commonwealth Government made provision for SOLS to pilot a GP obstetrician locum service.

SOLS aims to maintain and improve the access of rural women to quality local obstetric care by providing the rural specialist obstetrician workforce with efficient and cost-effective locum support.

In addition, SOLS aims to sustain safety and quality in rural practice by facilitating access to personal leave, professional development or breaks from on-call commitments for rural obstetricians.

The implementation of SOLS will support these aims by:
- Providing support for all non-metropolitan obstetricians and GP obstetricians in RRMAs 3-7
- Strengthening the synergies between the specialist obstetric and GP rural workforce
- Maximising the benefit of the Training Program for Rural and Remote Procedural GPs Program for eligible GP obstetricians.

What does SOLS provide?

- Up to 14 days subsidised locum relief to specialist obstetricians and GP obstetricians in RRMA 3-7[1]
- Subsidised travel, travel time and paid handover
- Further unsubsidised locum relief
- Arrangement to pay for registration, where medical registration is required in another jurisdiction
- Arrangements for Medicare provider numbers.

Outcomes

Specialist obstetricians

Who are performing the locum placements?
Specialist locums are drawn from active RANZCOG Fellows and include Fellows in transition to retirement, as well as new Fellows exploring the option of rural practice, with the majority of locums nearing retirement.

SOLS has 115 Fellows who have registered to support their rural colleagues. This represents a very positive response to SOLS. However, it needs to be remembered that the majority of locums are not able to respond to a request at short notice. If you are interested in supporting your rural colleagues, please contact the SOLS Secretariat via email: sols@ranzcog.edu.au or phone College House on +61 3 9417 1699.

Who can apply for a specialist locum?
SOLS accepts applications for locum placements from individual specialist obstetricians or from hospitals requiring obstetric locum support. SOLS has supported specialists in Area of Need positions and non-FRANZCOG holders with credentials to provide specialist obstetric service in remote communities.

How many specialist locum placements have been made and where were they?
1. SOLS pilot (July 2006 to September 2008)
There were 52 placements in rural and remote locations in Queensland, New South Wales, Victoria, South Australia and West Australia, which provided over 1100 days of locum relief to 111 rural obstetricians.

2. SOLS program (October 2008 to January 2009)
To date, locum placements have been arranged in 26 rural and remote locations in Queensland , New South Wales, Victoria, South Australia, Northern Territory and West Australia. These placements have provided 330 days of locum relief to 30 rural obstetricians.

What are the key challenges?

Responding to immediate requests
It is not always easy to fill locum placements at short notice, due to a lack of available locums with medical registration in the region; a lack of location specific provider numbers; and on occasions, a lack of private medical indemnity. Arranging medical registration and Medicare provider numbers usually takes a minimum of three weeks, in some cases longer.

As SOLS matures, locums are returning to practices/hospitals which can shorten the turn around time in arranging a placement.

GP obstetricians

In October 2008, SOLS received funding to expand the program to GP obstetricians. In consultation with the SOLS Advisory Committee and a panel of rural GP obstetricians, documentation was developed to support the SOLS administrative process and ongoing evaluation.

The rural and remote GP obstetric workforce was invited to register their interest in participating in SOLS as a locum and/or receiving a locum.

Supply of locums
By January 2009, the SOLS Secretariat had received 29 expressions of interest in providing locum relief. At this stage, locums will be

drawn from GPs with the DRANZCOG or DRANZCOG Advanced certification.

Demand for locum support
Locum support is available to all GP obstetricians credentialed to provide obstetric services. In the reporting period, the program received 30 expressions of interest from GPs requiring locum support. However the Secretariat had only received one application from a hospital for two short term placements for a GP obstetrician locum.

Number of placements
There are two completed locum placements in this reporting period. This is disappointing, although, given the short notice prior to the Christmas and New Year holiday season, it is most likely that any locum arrangements had been made well in advance, prior to the commencement of SOLS for GP obstetricians.

What can you do?

If you are a specialist or GP obstetrician, you can support your rural colleagues by registering to be a locum.

If you a specialist or GP obstetrician working in a rural or remote location, you will be eligible to receive subsidised locum relief.

What next?
In 2008, the SOLS Management Group, with the support of Commonwealth funding, undertook a series of workshops with other medical colleges and midwifery and nursing organisations to encourage them to develop a locum service for their rural and remote members. The surgeons, anaesthetists and dermatologists applied to the Commonwealth for funding to develop locum services. The Australian Society of Anaesthetists was granted funding.

Locum service for GP anaesthetists
The SOLS team supported the Australian Society of Anaesthetists in undertaking a feasibility study into the establishment of a SOLS program to support rural and remote GP anaesthetists. It is hoped that the Commonwealth Government will support this important sector of the maternity service workforce.

Notes

[1]Rural Remote Metropolitan Area (RRMA) which identifies seven categories of remoteness according to the population as recorded in the ABS 1991 Census of Population and Housing. These are capital city, other metropolitan centre, large rural centre, small rural centre, other rural area, remote centre and other remote area.

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 that two years, please see the re-entry policy following a prolonged absence from practice at: www.ranzcog.edu.au/publications/statements/wpi13.pdf.

For further queries contact:

Ms Val Spark
Continuing Professional Development Coordinator
Ph: +61 3 9412 2921
Fax: +61 3 9419 7817
E-mail: vspark@ranzcog.edu.au

Frank Forster Library News

Did you know...

The following library services are available to all RANZCOG members and staff:

Book loans
- Books are loaned for a period of three weeks and can be renewed if needed.
- If you are unable to come into the Library, books can be mailed out to you.
- To obtain a listing of books on a particular subject or by author title, contact the College Librarian who can email a list to you.

or

- Bookmark Libraries Australia at: http://librariesaustralia.nla.gov.au/apps/kss?mode=bas . Simply type in your title and a list of libraries holding that item will appear. Our library holdings symbol is VCOG.

Journal articles
The Library has a small collection of journals, however, there are internet sites that offer free access to articles. Contact the College Librarian who will process your request.

Literature searches
The College can offer information searches using databases such as *PubMed* and *Cochrane*.

Contact
Diane Horrigan
RANZCOG Librarian
(Tuesdays)
email: library@ranzcog.edu.au
tel: +61 3 9412 2927
fax:+61 3 9419 0672

Interested in donating to the Historical Collections?

We always welcome enquires regarding donations to the Historical Collections.

It is necessary to be highly selective when acquiring items due to the limitations of storage space and the cost of conserving and maintaining items in the collections. We usually avoid collecting duplicates. However, this policy may be varied in special circumstances, for example, rare books, a superior example of an item, or where the provenance is of particular interest or value.

If you have any items that you believe might be of value to the Collections and you would be interested in donating them, please see the instructions below:

- Compile a list of items with a brief description. For books include author, title, publisher, place and date. For archival and personal papers, include details. For museum items, include a brief description and the history of how you acquired it and attach a photograph.
- Email or post the list to one of the Historical Collections staff at the College.
- Contact the staff by telephone if you wish to discuss any items.

We look forward to hearing from you and would be delighted to consider any items you may wish to donate.

Staff contact details:

Librarian: Di Horrigan Tuesday 9am-5pm
ph: +61 3 9412 2927 email: dhorrigan@ranzcog.edu.au

Museum Curator: Gráinne Murphy Monday 9am-5pm
ph: +61 3 9412 2927 email: gmurphy@ranzcog.edu.au

Archivist: Ros Winspear Mon, Wed, Thu, Fri 9am-5pm
ph: +61 3 9412 2934 email: rwinspear@ranzcog.edu.au

Working to prevent maternal mortality in Timor Leste

Dr Afzal Mahmood
Discipline of Public Health
University of Adelaide

Dr Bruno Giorgio
FRANZCOG

Dr Steven Scroggs
FRANZCOG

Timor Leste is the world's newest nation and despite having huge oil and gas reserves, it is also one of the world's poorest nations.

After 25 years of occupation, followed by a bitter fight for independence, Timor Leste has very depleted infrastructure in all areas of government. This, in conjunction with a high birth rate, has resulted in high rates of maternal, neonatal and infant mortality.

At the end of 2005, the Rotary Australia World Community Service entered into a Memorandum of Understanding with the Timor Leste Ministry of Health, to assist the public sector health system provide better services for safe motherhood in Bobonaro district, Timor Leste. This Safe Motherhood Project is part of an Infancy, Midwifery, Obstetrics and Gynaecology (IMOG) program and is coordinated by the Rotary Club of Morialta, South Australia. The project is funded by Rotarian and non-Rotarian philanthropists and organisations, with technical support provided by specialists from the Discipline of Public Health, the University of Adelaide and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG). Many O and Gs and other medical specialists provide voluntary service as part of this project.

'The project aims to [improve maternal mortality] through strengthening antenatal care; birthing; postnatal care; emergency obstetric care; human resource development; referral systems; planning and management; and infrastructure development.'

The focus is on safe motherhood because the maternal and infant mortality rates of Timor Leste are among the highest in the world. The high total fertility rate of 7.7 is contributing to the high maternal mortality.[3] While about 43 per cent of pregnant women receive care from skilled healthcare providers, only about 14 per cent of women access antenatal care according to the recommended schedule. The project is based in the Bobonaro District which has a population of approximately 85,000. A large number of people live in small villages. Public transport is not available to many people in the rural and remote communities. The terrain is rough and hilly and often becomes impassable during the wet season.

The goal of the project is to improve maternal and child health. The project aims to achieve this goal through strengthening antenatal care; birthing; postnatal care; emergency obstetric care; human resource development; referral systems; planning and management; and infrastructure development. This is in line with the strategies recommended for safe motherhood, therefore, access to skilled birth attendants, quality obstetric care and access to contraception to avoid unintended pregnancies.[5] Community outreach for public health interventions, community involvement and improved utilisation of public sector health services are some of the project's strategies.

We all know that delay in access to appropriate obstetric care is a major cause of deaths in women during pregnancy and delivery. The three phases of delay include:

1. Delays due to lack of a prompt decision to seek care for women
2. Delays in reaching an adequately equipped healthcare facility
3. Delays in provision of effective care even after arrival at the facility.[2]

We noted that all three types of delays are contributing to maternal mortality in the Bobonaro district. Therefore, the project in Bobonaro is assisting the government health system by:

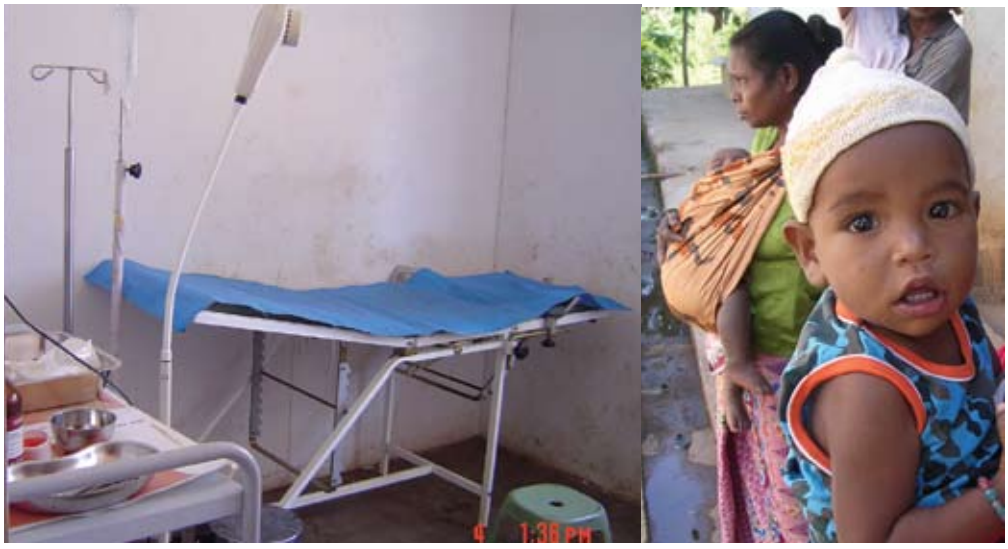
1) Removing the delays due to lack of decisions to seek care

We are assisting government staff in reaching out to the community to improve the understanding about the need for appropriate obstetric care. The project has provided eight motorbikes to the midwives and nurses stationed at the community health centres and health posts. The midwives are encouraged to: reach out and provide antenatal care; identify high-risk pregnancies; motivate women and their families to seek care provided by an appropriately trained midwife or doctor; and provide the community with information about how to contact a hospital and call for an ambulance.

2. Removing the delays due to lack of transport

Our project has provided an ambulance to the government health system, including ongoing funds for fuel, maintenance and a driver. Our team helped government staff to develop a log which provides information on the use of the ambulance and helps in planning better access for women in rural and remote areas. A midwife accompanies the ambulance driver for all obstetric emergencies. In the past, there was only one ambulance in the whole district, which at times was non functional due to lack of funds. The addition of an ambulance and the resources to keep it operating are a great asset. The driver, midwives and other associated healthcare staff feel privileged to be in a situation where they contribute to

The learning centre before and during development.



(Left) A treatment room at a health centre. (Right) Local community members at a health centre.

saving the lives of women suffering from pregnancy and delivery complications. This year, additional training for the ambulance staff was conducted by a visiting volunteer obstetrician and the need for supplies for the ambulance was reassessed.

3. Removing the delays due to lack of quality care at the health facilities

We are supporting government plans for upgrading community health centres (CHCs), health posts and the Bobonaro District Hospital. Visiting obstetricians and medical laboratory specialists have provided training to doctors, midwives and laboratory technicians. A building in the hospital premises, that was burnt during the independence struggle, has been re-built and converted into a learning centre by the project volunteers. There are six CHCs and 15 health posts in the Government health system Bobonaro district. However, at present, no deliveries are conducted at these centres and posts, nor are they equipped to provide safe emergency obstetric care. Building materials, construction equipment and supplies have been procured and plans are underway for the renovation and construction of consulting rooms and delivery suites at the two CHCs in Cailaco and Atabae. As a consequence, these centres will be able to provide emergency obstetric care. This upgrade is to start in March 2009. Such developments provide the additional benefits of contributing to the local economy, as considerable sums of money are spent to purchase materials and temporary jobs are created as well. The staff at CHCs, including nurses and midwives, are highly motivated. They need adequate facilities, equipment and some additional training to make optimum use of the upgraded facilities. The list of equipment and medicine needed is prepared in line with what is recommended for basic emergency obstetric care. These requirements can easily be met at low cost once the facilities are upgraded and staff have the additional training.

Health is a fundamental human right and governments have a responsibility to make sure that people have easy access to quality care. With a philosophy that overseas aid should contribute to the sustainable development of local systems and considering the vital role of governments, we think it is essential to work together with the Timor Leste Government. For these reasons, we have refrained from initiating separate and parallel services in Bobonaro.

We understand that removing the delays in accessing the obstetric care is not sufficient by itself. The recommended strategies for reducing maternal mortality include access to skilled birth attendants

and quality obstetric care; access to contraception to prevent unintended pregnancies; and measures to address other health and reproductive health issues[6] such as high prevalence of malaria; anaemia; infections; malnutrition; reproductive tract infections; and sexually transmitted infections. Therefore, the project team, including midwives and public health professionals, will be working with the community and government healthcare staff to improve outreach services, provision of health education, vaccinations, contraceptives, malaria bed nets and nutritional supplements.

Working on these tasks is not without challenges. There are very few local trained midwives and doctors in Timor Leste. Identifying locals to work on projects like ours is difficult. Volunteers from Australia are generally only available to work overseas for a short period of time and that makes it difficult to forge effective working relationships in the local setting. To some extent, language barriers affect the capacity of volunteers to provide support. Occasional internal conflicts in Timor Leste and the associated violence and displacement of people have also affected the health services development efforts. Those post-conflict challenges have been presented in some detail in a recent article by Marlowe and Mahmood (2009) in the Asia Pacific Journal of Public Health.[1] The project has contributed to our learning about the challenges and allowed us to gain knowledge on how to overcome those challenges. We intend to use these learning experiences to continue input in Timor Leste and in other developing communities.

(L to R) Dr Bruno Giorgio, Dr Steven Scroggs and Dr Afzal Mahmood.

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FSEP
FETAL SURVEILLANCE EDUCATION PROGRAM

Online program released

On behalf of the FSEP team, we are please to announce the launch of our Online Program (OFSEP). The OFSEP has been designed specifically to complement the range of face-to-face programs the FSEP offers. The program is easy to use and can be accessed from work or home. New modules are still being developed and uploaded. Importantly, the OFSEP is an evolving resource, completely under our control, that will continue to be updated and expanded as required.

The OFSEP comprehensively covers a variety of fetal surveillance information including, fetal heart rate physiology, the normal CTG, the abnormal CTG, maternal heart rate monitoring, Doppler assessment, clinical cases, sample questions and more!

The OFSEP is offered free to those institutions using the FSEP face-to-face education programs.
The OFSEP is now also available as a stand-alone product.

The RANZCOG Fetal Surveillance Education Program (FSEP) is a highly successful education program, run on a not-for-profit/cost-recovery basis, with workshops delivered throughout Australia and New Zealand.

The FSEP currently provides education to over 120 hospitals. FSEP programs have already been delivered to more than 8500 participants, with a high demand for ongoing education. Participant feedback following the sessions continues to be consistently positive. There is also a high degree of participant satisfaction and a perceived positive influence on practice resulting from the education.

Of primary importance to the future of the FSEP is the development of a valid and reliable tool to assess competency in fetal surveillance, across all clinical groups. The FSEP is developing such a tool, with the assistance of the Assessment Research Centre in the Faculty of Education at the University of Melbourne. This tool is currently being piloted across Australia and New Zealand.

Work is well under way on the development of a fetal monitoring handbook. This book will act as an additional resource to support the face-to-face and web-based components of the program and will integrate with the FSEP, OFSEP and the RANZCOG Intrapartum Fetal Surveillance Clinical Guidelines.

Videoconferencing of the 'refresher' program, following a successful trial, can now be provided to remote rural sites at a significantly reduced cost.

The RANZCOG FSEP is ultimately aiming to provide a cost-effective suite of products, targeted specifically to meet the learning needs of clinicians across Australia and New Zealand. Of equal importance is the need to address the risk management requirements of participating institutions in the area of fetal surveillance.

To find out more about this exciting educational opportunity, please contact:

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

Brian Spurrett Foundation gives meaning to professional networking in the Pacific

A/Prof Rajat Gyaneshwar
Chair
Brian Spurrett Foundation

Richard Gilfillan
Midwifery Educator

Carmel Walker
Coordinator
Brian Spurrett Foundation

The Brian Spurrett Foundation (BSF) continues to support Pacific midwives in undertaking fellowship placements in Australia, in spite of the current global economic downturn and its flow-on effect on the funding available for BSF Fellowships.

During November 2008, the Sydney South West Area Health Service (SSWAHS) was host to three midwives from the Pacific undertaking BSF fellowships, two from Fiji and one from the Federated States of Micronesia. Their stories are described further on.

On 14 November, a successful social and fundraising day was organised by Mrs Kerry Spurrett and friends at the family homestead, 'Fairlight' in Mulgoa, New South Wales, Australia. There were many beautiful French gifts, jewellery, *pashminas, objet d'art* and children's ware. The BSF fellows visited Kerry at Fairlight on this fundraising day and were presented with quilts made by students at Colyton High School.

As members of RANZCOG are well aware, the Brian Spurrett Foundation seeks to continue the legacy of Brian Spurrett in his commitment to promote and raise awareness of maternal and child health in the Asia Pacific region. In particular, the BSF provides practical assistance through offering opportunities for training and education for doctors and midwives from the Pacific Islands, both in Australia and New Zealand, and within their own local hospital environment. Brian Spurrett fellowships are offered annually and give exposure to Pacific reproductive health professionals to practices in a range of hospital areas and clinics. BSF seeks to strengthen the network and bond between colleagues across our region and through the Pacific Society for Reproductive Health (PSRH).

BSF extends it warmest appreciation to all supporters for their dedicated and focused support of the Foundation, especially those who participated in the fundraising which raised A$6000.

Brian Spurrett Fellowships 2008

Midwives from Fiji and the Federated States of Micronesia (FSM) have recently undertaken a four-week fellowship placement in the Sydney South West Area Health Service (SSWAHS), under the supervision of Dr Rajat Gyaneshwar and Mr Richard Gilfillan, Area Nurse Educator, with assistance and support from Professor Pat Brodie.

During the visit, the midwives experienced a range of activities including visits to labour and maternity wards; training in parent education; training in midwifery support in the community; visits to antenatal clinics and day assessment units at the Liverpool and Fairfield Hospitals; attendance at midwifery support meetings in the health service network; and visits to Cooma and Bowral hospitals. The visiting nurses found the meeting structure useful and were impressed by the fact that all levels of staff are able to discuss agenda items and then provide feedback to the ward staff. Dr Rajat Gyaneshwar, staff specialist at Liverpool Hospital and Chairman of the BSF Management Committee summarises, 'The fellowships make a valuable contribution to reproductive health professional capacity building in the Pacific. With experience we have been able to tailor the fellowship to match individual needs, even though on this occasion, we had three fellows, each with different needs and expectations. The senior management at Liverpool Hospital and the SSWAHS have been very supportive. This high level of recognition means that the BSF fellows are welcomed throughout the organisation. Richard and I are therefore able to ensure that the BSF fellows get meaningful,well organised and planned exposure to the experiences they seek. The regular debriefing sessions allow us to finetune the program as necessary.'

Another positive aspect was that the staff at Liverpool Hospital were positively engaging the fellows in professional networking. Indeed, several of the BSF fellows are seeking opportunities to visit other fellows in their work places.

The following brief profiles of the 2008 Brian Spurrett fellows outline their backgrounds and views on their fellowship experiences in Sydney.

Aporosa Samu Vakaotia
BSF fellow
Midwife (Fiji)

Sam is a midwife who experiences shortagea in staff at Nausori Maternity Hospital, Viti Levu, on the main Island of Fiji. The hospital cares for a population of 72,000 and there is only one maternity unit which sees 1500 to 2000 deliveries per year and caters only for low-risk patients and normal deliveries. 99 per cent of deliveries occur in hospital and only one per cent at home. Staffing consists of one midwife and two registered nurses each shift (eight-hour shifts) and emergency obstetric cases are transferred to the main hospital at Suva, about 20 minutes by ambulance.

Sam returned to Fiji with new knowledge on how to review the transfer and referral of obstetric patients so that all referrals will be appropriate and cost-effective.

Chandra Dayal
BSF fellow
Midwife (Fiji)

Chandra works in the paediatric unit of Colonial War Memorial Hospital, Suva. Since 2004, she has been working in the children's out-patient clinic as the acting senior nurse. Chandra's experience also extends as a trainer in the Integrated Management of Childhood Illness (IMCI) program, a breastfeeding counsellor, an external assessor for the Baby Friendly Hospital Initiative, and a preceptor for nursing students and midwives. 'It is quite challenging as there is increased commitment in an under-resourced environment and it leaves me with little or no energy to reflect on or try new approaches,' Chandra says.

Chandra says that she has been 'overwhelmed with the richness of experiences and knowledge shown by the health workers' and has left Australia armed with information and strategies on how to reorganise the outpatient clinics to be more efficient. Chandra also now feels the desire to return to midwifery. 'Being surrounded by experts, professionals and educators has really given me a whole new perspective on issues in primary healthcare: mainly equity, access and quality of healthcare in one's own practice. There have been lots of opportunities to network with Australian colleagues. I had not done this before and it has been a great opportunity to meet and make new friends.'

Efrosina Moufa
BSF fellow
Midwife (Federated States of Micronesia)

Efrosina is a midwife at Chuuk Maternity Hospital in the Federated States of Micronesia (FSM), a country which has a population of 80,000. The hospital delivers approximately 300 babies each year. Due to staff shortages, the midwives work 12-hour shifts (there are four midwives, one registered nurse and five nurse aids) in a 12-bed maternity unit and a four-bed labour ward. The midwives do all of the procedures: delivering labouring patients; dealing with antenatal and postnatal complications; and providing critical care for newborns.

The BSF fellowship was very valuable to Efrosina, as she was able to recognise that the management of their maternity unit in FSM needs improving. Parent education is lacking and infection control is a big problem, especially as surgical gloves are reused. Instruments are rusted and sometimes there is no water supply if the power fails.

Richard Gilfillan, midwifery supervisor for the BSF fellows' visit to SSWAHS summarises: 'I have again been enriched both personally and professionally by working with my friends and colleagues from the Pacific. It is very rewarding to help formulate objectives, implement plans and see positive results at the end of four weeks. The fellows have left Australia with strategies set in place as change agents and it is exciting to see the development of quality projects. I look forward to seeing the results. These projects are:

- Appropriate referrals of obstetric patients from Nausori to Suva (Nausori Maternity Hospital, Fiji)
- Implementation of effective handwashing and hygiene to reduce puerperal sepsis (Chuuk Maternity Hospital, FSM)
- Investigation of the effect of non-intervention of umbilical cord care of newborns (Colonial War Memorial Hospital, Fiji).

Fundraising event at the Spurrett family homestead, Fairlight, Mulgoa, New South Wales, Australia.

Brian Spurrett fellows with Dominic and Gracie Spurrett (far left) and Mrs Amelia Spurrett (front).

Chandra Dayal, of Fiji, receiving a quilt from Mrs Kerry Spurrett.

Australian and New Zealand Honours Awards

The following RANZCOG Fellows recently received Australian and New Zealand honours awards:

New Zealand New Year Honours 2009

Professor Ronald Jones (CNZM)
Awarded the Companion of the New Zealand Order of Merit for services to women's health.

Australia Day Honours 2009

Dr Elizabeth Farrell (AM)
Awarded a Member in the General Division of the Order of Australia for service to medicine in the field of women's health, particularly obstetrics and gynaecology through research; clinical practice; education and administrative roles; and as a contributor to a range of professional organisations.

Dr Malcolm Stening (OAM)
Awarded the Medal in the General Division of the Order of Australia for service to medicine as a gynaecological surgeon and to the community through the recording of naval history.

RANZCOG Rural Diplomates Days

Held in conjunction with the 2009 Provincial Fellows Annual Scientific Meeting.

28 and 29 May 2009

Cable Beach Club Resort, Broome, Western Australia

Contact: Ms Kate Lawrey
tel: +61 3 9412 2971

email: klawrey@ranzcog.edu.au
web: www.ranzcog.edu.au/fellows/provincialmeeting.shtml

NT
NUCHAL TRANSLUCENCY
ULTRASOUND, EDUCATION & MONITORING PROGRAM

The Nuchal Translucency Ultrasound, Education and Monitoring Program is an education and credentialing program initially funded by the Federal Government's Department of Health and Ageing for all practitioners performing Nuchal Translucency Screening for pregnant women.

The primary objective of the program is patient care. The RANZCOG, in conjunction with the Fetal Medicine Foundation (FMF) in the United Kingdom, has set up a process for certification in the 11-14 week scan to ensure that all those performing this ultrasound examination have been adequately trained to do so and that high standards of performance are maintained by continuous education and audit.

Over 1000 delegates have participated in the program since it began in October 2001 and the twice yearly face-to-face theoretical courses continue to reach maximum capacity. We are about to build our online education facility which will address the needs of first time learners who are embarking on becoming certified in the performance of the first trimester NT ultrasound scan. The online theoretical course will eventually replace the face-to-face course.

Requirements for Certification in the 11-14 week scan are:
1. Attendance at a FMF/RANZCOG recognised theoretical course and completion of a multiple-choice questionnaire.
2. Submission of a logbook of 25 images demonstrating the candidate's measurement of the Nuchal Translucency.
3. Completion of a practical assessment in the performance of the 11-14 week scan.

Once the certificate of training in the 11-14 week scan has been obtained, candidates are entitled to receive the FMF software for the calculation of risk for Down syndrome using maternal age, Nuchal Translucency measurement and maternal serum free ß-hCG and PAPP-A.

For further information, please contact:
Nuchal Translucency Coordinator (t) +61 3 9412 2938 (e) nuchaltrans@ranzcog.edu.au

RANZCOG
Research Foundation

DID YOU KNOW?

RANZCOG RESEARCH FOUNDATION FACT SHEET

- 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.

RANZCOG Research Foundation (ABN 23 004 303 744)
College House, 254-260 Albert Street, East Melbourne, Victoria 3002, Australia
t: +61 3 9417 1699 f: +61 3 9419 0672 e: researchfoundation@ranzcog.edu.au w: www.ranzcog.edu.au/research

RANZCOG Women's Health Award 2008

Julia Serafin
Media, Marketing and Communications Senior Coordinator

Since 2005, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) has been proud to present the RANZCOG Women's Health Award, valued at A$500, 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 2008 was received by the following successful awardees:

Jane Healy
School of Paediatrics and Reproductive Health, University of Adelaide

Thasvir Singh
University of Auckland

Catherine Philps
School of Clinical Medicine, Australian National University

Nina Ziegler
Faculty of Health Sciences, Flinders University

Alicia Smith
Griffith University

Sally Litster
Margaret Reilly (deceased)
School of Medicine, James Cook University

Rehana Ratnatunga
School of Medicine, University of Melbourne

Amanda Henderson
Dunedin Medical School, University of Otago

Peter Moore
University of Queensland

Siew Won Law
University of Tasmania

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

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
Continuing Professional Development Coordinator
(t) +61 3 9412 2921
(f) +61 3 9419 7817
email: vspark@ranzcog.edu.au

APPLICATIONS FOR SUBSPECIALTY TRAINING POSITIONS FOR 2010

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 2010 have completed the Integrated Training Program and preferably 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 2010 application form available on the College website at www.ranzcog.edu.au/trainees/subspeciality-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 Susan Westcott
tel: +61 3 9412 2941
fax: +61 3 9419 7817
email: swestcott@ranzcog.edu.au

Further information about the training programs can also be viewed on the College website at www.ranzcog.edu.au .

Applications for all positions close on Friday, 27 March 2009.

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

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 that two years, please see the re-entry policy following a prolonged absence from practice at: www.ranzcog.edu.au/publications/statements/wpi13.pdf.

For further queries contact:

Ms Val Spark
Continuing Professional Development Coordinator
Ph: +61 3 9412 2921
Fax: +61 3 9419 7817
E-mail: vspark@ranzcog.edu.au

RANZCOG Rural Diplomates Days

Held in conjunction with the 2009 Provincial Fellows Annual Scientific Meeting.

28 and 29 May 2009

Cable Beach Club Resort, Broome, Western Australia

Contact: Ms Kate Lawrey
tel: +61 3 9412 2971

email: klawrey@ranzcog.edu.au
web: www.ranzcog.edu.au/fellows/provincialmeeting.shtml

2009 Provincial Fellows Annual Scientific Meeting

28 to 31 May 2009

Cable Beach Club Resort, Broome, Western Australia

Contact: Ms Kate Lawrey
tel: +61 3 9412 2971

email: klawrey@ranzcog.edu.au
web: www.ranzcog.edu.au/fellows/provincialmeeting.shtml

CORRECTION TO DIPLOMATES WOMEN'S REPRODUCTIVE HEALTH REQUIREMENTS FOR THE 2008–2010 TRIENNIUM

Holders of the DRANZCOG and DRANZCOG Advanced with a certificate end date of 31 December 2010 have recertification requirements. In the current triennium, Diplomates must remain financial members of RANZCOG and obtain points in the area of Women's Reproductive Health as follows:

Diplomates who are Fellows of, or vocationally registered with the RACGP:
Women's Health requirements for 2008-2010 in the RACGP QA&CPD Program are a total of 40 points (one Category 1 activity) in Women's Reproductive Health activities.

Diplomates who are Fellows of, or vocationally registered with ACRRM:
Women's Health requirements for 2008-2010 in the ACRRM PD Program are 40 points in Women's Reproductive Health activities from the extended skills mandatory category (excluding ACRRM Teaching Practice Accreditation).

Diplomates who are NOT Fellows of, or vocationally registered with the RACGP or ACRRM:
Women's Health requirements for 2008-2010 are a total of 40 points (one Category 1 activity) in Women's Reproductive Health activities.

For further information:
Ms Val Spark
CPD Coordinator
ph: +61 3 9412 2921
email: vspark@ranzcog.edu.au

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