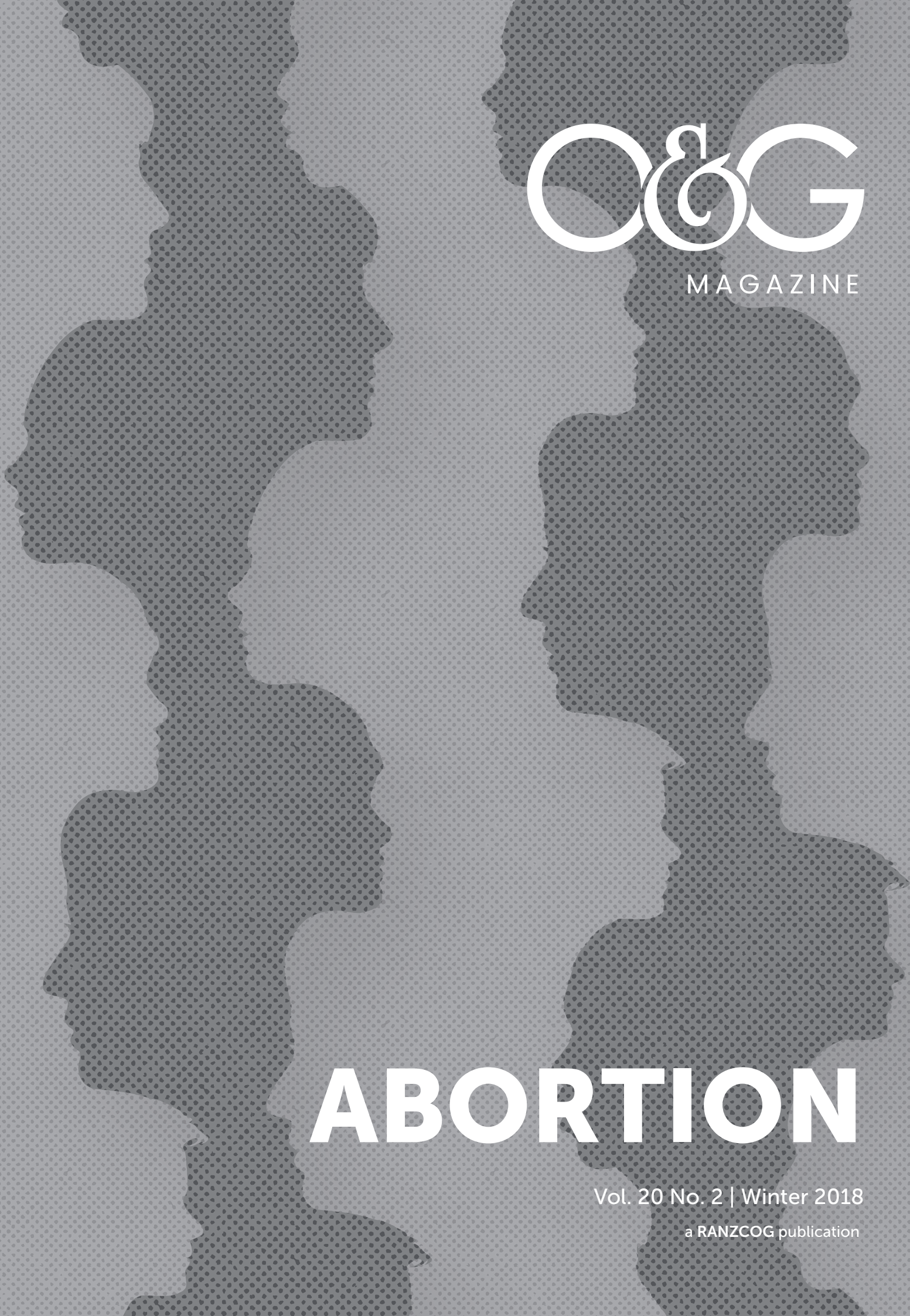

O&G MAGAZINE

ABORTION

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Abortion

Special feature

Women's health

The College

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From the President

Prof Steve Robson
President

The recent state election in Tasmania revealed that women's access to reproductive health services, safe abortion in particular, is of enormous interest and importance to our communities. When safe abortion services are not available to women, the risk of morbidity and maternal mortality increases. Globally, unsafe abortion contributes to one in eight maternal deaths. Thus, the College supports equitable access to termination services on the basis of healthcare need. Services should not be limited by age, socioeconomic disadvantage or geographic isolation, as can happen in many parts of Australia and New Zealand. Women have the right to access medical services without their privacy being infringed or being subjected to harassment.[1]

Access to safe and dignified abortion was the subject of a series of articles by journalist Gina Rushton of *BuzzFeed Australia*. I was delighted to present Gina with her award as joint winner of the RANZCOG Media Excellence Award during March Council Week. This issue of *O&G Magazine* deals with important issues related to termination of pregnancy, examining topics such as advocacy, law, ethics and conscientious objection. I commend the *O&G Magazine* editorial group for presenting a balanced examination of what can be a contentious issue.

National Strategic Approach to Maternity Services

Most of you will recall the first unsuccessful attempt to develop a new 'framework' for maternity services in Australia. The project, run by the Queensland Government and managed by Deloitte Consulting, was a resounding failure and the attempt was abandoned in the middle of last year. The upside was that the College developed a framework, released in the latter part of 2017, in close collaboration with the colleges of anaesthetists, psychiatrists, general practitioners and rural and remote practitioners, the AMA, and many other professional groups.

An attempt at a government-mandated 'framework 2.0' has begun, this time grandly titled the National Strategic Approach to Maternity Services (NSAMS). I am representing the College on the advisory group to the NSAMS. At this point, I am not quite sure what to make of the new venture. Australia has a wonderful record of safety for women and their babies, and we should be very proud of this. The key to good outcomes is collaboration between professional groups. What the NSAMS aims to achieve is as yet unclear. I will keep you updated on the progress of this government-led initiative.

Private healthcare in Australia

You will have seen headlines relating to private health insurance (PHI) and out-of-pocket costs for care in Australia in the media recently. Australia has a good balance of public and private care, but there is clear

evidence that the affordability of private care now represents a major threat to the viability of the entire private healthcare system. This is of major concern to me and the College. Public hospitals are under intense pressure and waiting lists for elective surgery are increasing.[2] In particular, the number of women having their babies in private hospitals is falling rapidly. Many of you will have personal experience of this from your own hospitals and practices.

I am a member of Federal Health Minister Greg Hunt's Ministerial Advisory Group on Out-of-Pocket Costs. The group, which has met twice, is chaired by the Chief Medical Officer for Australia, Prof Brendan Murphy, and consists of a small group of representatives from procedural colleges, PHIs, private hospitals, the AMA, and consumer groups. The group is aiming to develop a 'transparency model' to assist patients and their family doctors in accurately estimating gap costs for main procedures. This is a difficult and complex process, but the group should make its recommendations to the Minister before the end of the year.

Transvaginal mesh

Many Fellows will have used transvaginal mesh kits for the management of prolapse and may still use mid-urethral tapes for stress incontinence (the kits have been withdrawn from use). After a long evidence-gathering process, and some delays, the Australian Senate Inquiry released its report on mesh last March. There are a number of lessons for the College arising from the evolving mesh story, and I am going to be speaking about this at the RANZCOG Annual Scientific Meeting in Adelaide later this year. It promises to be a great meeting and I encourage as many College members to register as possible. I look forward to catching up with old friends and making new friends at the ASM.

Getting social

A key area of focus in my Presidential term has been engagement with younger Fellows and the community. I have been lucky to have a skilled and motivated team at the College. We have been striving to engage people through the College website and on social media platforms such as Twitter and Facebook. Whatever you think of these tools, there is no doubting their power and reach. I welcome any suggestions for further improving College communications. Feel free to let me or the communications team know your thoughts and ideas @DrSteveRobson @RANZCOG.

References
1. C-Gyn 17: Termination of pregnancy.
2. AMA Public Hospital Report Card.

From the CEO

Alana Killen
CEO

Since the conviction of UK specialist trainee, Dr Hadiza Bawa-Garba, for manslaughter on the grounds of gross negligence and her permanent removal from the medical register by the General Medical Council, many doctors have raised concerns regarding the court case and the role that Dr Bawa-Garba's reflections played in the decision of the jury.

Reflective practice is a critical element of a practitioner's professional development. The ability to critically self-appraise and identify areas for improvement form the foundation of the path to mastery. It is a practice that most undertake unconsciously, or at least, without formal documentation.

The Medical Board of Australia's newly developed Professional Performance Framework (which was previously referred to as CPD or MOPS) has five pillars, one of which relates to fostering a positive culture of medicine and encourages doctors to: 'Commit to reflective practice and lifelong learning'. As part of the new framework, doctors will be required to establish a Professional Development Plan (PDP) that will be based on the individual's learning needs and scope of practice. Measurement of outcomes will be a requirement and this may be achieved through clinical audit, review of medical records and reflection of professional outcomes. It is likely that the Medical Council of New Zealand will introduce similar guidelines, as they are currently reviewing revalidation requirements and have been closely involved in the development of the Australian regulations.

For some, the Bawa-Garba case has raised significant concerns about the legal ramifications of reflective practice and provided a reason why this should not form part of a practitioner's CPD or training. In the face of rising concerns and criticism, Dr Bawa-Garba's defence body (MPS) confirmed that her e-portfolio did not form part of the evidence before the court and jury. In a statement on the 1 February 2018, they said:

'The court was clear that reflections were irrelevant to the facts of the case and that no weight should be given to remarks documented after the event. The doctor's e-portfolio is a vital part of their professional development. It allows open and honest recording of reflections on incidents and is a crucial tool in bringing about a shift to an open learning culture where lessons are learnt and there are continual improvements to patient care.'

In Australia, the Department of Health currently grants Commonwealth Qualified Privilege (QP) to evaluation activities such as practice review, multi-source feedback, morbidity and mortality reviews and patient surveys. In New Zealand, according to Section 54 of the Health Practitioners Competence Assurance Act 2003, the Minister of Health can grant protection of a quality assurance activity. This protection recognises the importance of engaging in regular and effective quality assurance activities.

RANZCOG currently has QP for its practice visits, which individual practitioners can also apply for via the Department of Health website: www.health.gov.au/internet/main/publishing.nsf/Content/qps-info.

It is anticipated that the College will seek QP for activities such as multi-source feedback, as part of the College's CPD program, once the new Professional Performance Framework is implemented.

Accommodation

As many of you are aware, the question of future accommodation needs for the College has been under discussion for some time. The Board has investigated a number of options and sought input from College members. We are now undertaking preliminary discussions to redevelop the current College site and potentially enter a joint venture arrangement with a property developer. Ideally, this would enable the College to retain the existing presence (including the heritage listed buildings facing Albert Street) and construct (for example) apartments or offices at the rear of the building. College House would retain a separate entrance and it would provide the opportunity to create meeting spaces, training rooms and additional offices while retaining the library, Council Room and other historic features. Although planning is still in the early stages, this option meets the need for increased accommodation while maintaining the desirable East Melbourne location. We will continue to provide updates as the project progresses.

Pearson Vue and online examinations

I was horrified to learn of significant issues associated with the recent RACP examination, where candidates were locked out of the examination due to technical issues. In addition, there were reports of poor or no invigilation, which left candidates frustrated, angry and distressed. As Pearson Vue is the current provider of RANZCOG's online examination, we were anxious to meet with them to ensure these issues were not repeated during the next FRANZCOG written examination. Following this meeting, the College has decided to:

- Have paper copies available at the next examination as a back-up
- Reduce the number of sites at which the examinations is conducted
- Ensure there are RANZCOG staff present at each site
- Ensure non-RANZCOG invigilators are appropriately inducted and trained

While we cannot guarantee that an examination will be problem free, the College is satisfied that appropriate mitigation strategies have been put in place to alleviate any potential issues. An important underlying principle is that no candidate will be disadvantaged because of a system or College error. While this does not compensate for a disrupted examination, it hopefully provides reassurance to those who are planning to sit the examination in the near future.

New President

Finally, we would like to offer our congratulations to Dr Vijay Roach on being voted President-Elect at the Council meeting in March. Vijay will take over as President following the Annual General Meeting in November.

LEADERS IN FOCUS

Dr Kirsten Connan
MBBS (Hons), FRANZCOG, DDU
MMedEd (Gender and Leadership)

This feature sees Dr Kirsten Connan in conversation with RANZCOG members in a broad range of leadership positions. We hope you find this an interesting and inspiring read.

Join the conversation on Twitter
#CelebratingLeadership @RANZCOG @connankf

Prof Judith Goh AO
Urogynaecologist & VVF Surgeon

Prof Judith Goh is a subspecialist urogynaecologist based in Brisbane. She spends up to three months a year in developing countries training local doctors in vesico-vaginal fistula (VVF) repair.

Prof Goh spent her childhood in Malaysia, before moving to Townsville with her family. She attended medical school at the University of Queensland, completed her FRANZCOG, and spent her final six months of registrar training in Ethiopia with Dr Catherine Hamlin AC at the Addis Ababa Hospital in 1995.

After five years in specialist positions in Brisbane and on the Gold Coast, and a further period in Addis Ababa Fistula Hospital, Prof Goh completed her CU (Certificate of Urogynaecology) subspecialty training. This was undertaken at the Mercy and Royal Women's Hospital in Melbourne. Prof Goh now holds both public and private appointments in Brisbane.

Where does your overseas aid work take you?
I've travelled abroad to provide medical aid since 1995. This has included Ethiopia, Cambodia, Myanmar, Bangladesh, Ghana, Uganda, Tanzania and the Democratic Republic of Congo. I've also spent time on a Mercy Ship off the coast of West Africa. The focus has primarily been on training doctors and nurses in the management of obstetric fistula and pelvic organ dysfunction.

In 2011, we were able to secure support through Health & Development Aid Abroad (HADA), which now enables us to fundraise and provide tax deductions on all donations for our work overseas.

What are the challenges of providing overseas aid?
Some of the countries we work in have very high rates of HIV, with needlestick injuries common. The Mercy Ship was not able to continue its work in 2013 off the west coast of Africa due to Ebola. Infectious diseases are always a significant concern.

In many countries, women do not have the same levels of education and status as men. This challenges their cultural acceptance of our support to empower and teach them. In some parts of Africa, a commonly held belief is that 'women should not be doctors'. With limited-to-no education, and few female role models, it becomes hard for African women to envision an alternative pathway in life. We hope to challenge and change this.

What are the rewards of being involved with overseas aid?
Many! It is extremely rewarding and it certainly makes me value life in Australia. I was privileged to learn fistula repair surgery, and although the work and environment can be challenging, the impact on women's lives is profound. The skills I have learned have also greatly benefited my own surgical practice.

What roles do you currently hold with RANZCOG?
I am a representative on the CU Committee and have been involved in the CU subspecialty exams. I am involved in the RANZCOG perineal workshop, the Pacific Society of Reproductive Health (PSRH) and the Asian & Oceanic Federation of Obstetrics & Gynaecology (AOFOG).

I have current commitments with the International Urogynecological Association (IUGA) and the International Continence Society (ICS) through the ICS-IUGA Joint Report on the Terminology for Female Pelvic Floor Fistulae.

What drives your professional aspirations?
I was the child of migrants. Watching my parents struggle as a child was very motivating for my

educational and professional pursuits. Working overseas constantly reminds me to appreciate everything I have in life, and my personal Christian faith has played an essential part of my life and my drive.

I feel strongly that we should all push ourselves to our highest potential and my goal is to see the next generation succeed much further than I have. Very early in my career, I was fortunate to have a fantastic mentor, Dr John Markus, who provided supportive encouragement and was outstanding at debriefing.

How have you sustained yourself during your professional career?

Self-care is invaluable. Exercise plays a large role for me. I get out and run. I don't take my phone with me! Going overseas is very energising and sustains me in my practice here in Australia.

What have been the greatest highlights of your career?

Receiving the Order of Australia in 2012, training as a VVF surgeon and now being able to train others.

What three words would you use to describe your life?

Manic, fulfilling, content.

Prof Goh as Batonbearer in the Queen's Baton Relay for the Gold Coast 2018 Commonwealth Games.

Do you see yourself as a leader?

I feel this comes with all medical specialist roles, especially subspecialists. After nearly two decades of experience with fistula work, I am viewed as a leader in this field. If this allows me to be a role model for other women, that's great!

Do you see yourself as a feminist?

If I follow the Oxford English Dictionary definition of feminism, 'The advocacy of women's rights on the basis of the equality of the sexes', then yes. We will not reduce rates of VVF and maternal mortality without empowering young women in these at-risk communities.

What are the challenges for current trainees?

The reduced working hours has contributed to poor levels of surgical experience for most trainees. This has led to subspecialty trainees starting CU with limited surgical knowledge and skills. Trainees are increasingly choosing to invest in areas such as ultrasound and laparoscopy. These skills significantly limit overseas volunteer opportunities, which could be a valuable part of a specialist's career. In low-income areas of developing countries, there is virtually no laparoscopy available, limited imaging, and often, electricity is unreliable and susceptible to power surges.

Looking back over your career, would you choose to do anything differently?

Not really. I am a very positive and realistic person. I know what I'm good at, I've worked hard and I've made opportunities for myself. My biggest challenge is balancing time here in Australia with overseas. As I am self-funded, when I retire here, it will limit my overseas opportunities.

Do you feel RANZCOG is heading in the 'right' direction?

I feel obstetrics and gynaecology are very closely related as specialties and are complementary. The biggest challenge I currently see for RANZCOG is the number of trainees. The large numbers we now have are creating a dilution in experience for both trainees and specialists, especially with regards to surgery. We need to consider the role of unaccredited registrars or career medical officers for service provision in O&G departments, so that trainees can focus primarily on training.

Have you seen workplace culture change during your career?

Specialty training is much more competitive these days. Some trainees are less willing to engage in opportunities for 'extra experience' and are less well-read. The former is probably a reflection of the reduced working hours, more trainees and changes in trainee culture. Previously, we spent many non-rostered hours at the hospital to gain extra experience.

Having a work-life balance is valuable, but if you want good experience and surgical skills, trainees will increasingly need to look at other opportunities (simulation, assisting, overseas work) to gain surgical skills.

Are you currently involved in any research?

I supervise medical students and residents with their research. My CU colleague, Dr Hannah Krause,

is currently completing a PhD on our VVF work in Uganda. In many of our overseas aid countries we are engaged in projects, including research on fourth-degree tears, prolapse and domestic violence.

Do you have any words of wisdom to share?
Be open to all opportunities in your training and make yourself available. Training should be a great adventure of experience! Go overseas. We all live very comfortable lives as doctors in Australia and New Zealand. I would encourage everyone to give back to their community and consider volunteer work at home and abroad. Aid work has added to my practice and benefited my work here in Australia.

Since this interview, Prof Goh has been awarded the 2018 AMA Woman in Medicine Award, which will be presented at the AMA conference in May.

Prof Goh is available for career advice and mentoring in the area of urogynaecology. She holds a strong interest in overseas aid.

Prof Michael Quinn AM
Gynae-oncologist & President of IGCS

Prof Michael Quinn graduated from the University of Glasgow and began his medical career at the Glasgow Victoria Infirmary in 1973. After passing the MRCP and MRCOG, he accepted a research position at the Royal Women's Hospital (RWH) in Melbourne.

Following two years of postgraduate gynae-oncology training in Canada, Prof Quinn returned to Melbourne as a consultant at the Peter MacCallum Cancer Centre, and as the Director of the Hydatidiform Mole Registry at RWH. In 1988, he become the Director of Oncology at RWH.

Prof Quinn retired from clinical practice in 2016, with over 350 publications and authorship of multiple monographs and books. He has personally raised more than A$1,000,000 in sponsorship for gynae-oncology research through marathon running, road cycling, and mountain climbing adventures, and A$3,000,000 for renovating the unit at RWH.

Prof Quinn is President of the International Gynaecologic Cancer Society (IGCS), having developed global curriculum and mentorship programs in Vietnam, Mozambique, Ethiopia, Kenya, Zambia, Liberia, Guatemala, Fiji and Indonesia. Under Prof Quinn's presidency, the IGCS has committed to achieving 50 per cent female representation on the society's board by 2022.

What drew you into a career in gynae-oncology?
I loved both obstetrics and gynaecology, but I could see a huge need in gynae-oncology. During my time in Canada, the multi-disciplinary aspect of oncology care and team collaboration was inspiring. I felt this was something Australia needed and our local units could emulate.

What changes occurred in gynae-oncology during your time as Head of Department?
When I started in the role in 1998, the RWH inpatient facility was a historical 'Nightingale' ward, with large open multi-bed rooms and only one shared bathroom. With lots of out-of-hours talks and sharing of women's cancer stories around many tables, clubs and organisations, as well as a number of marathons (Sponsaprof), we raised funds to convert our ward into 21 spacious single rooms (all with en-suites and access to a communal kitchen and laundry). We also provided a double bedroom, enabling partners to stay during palliation. This was such an important change for the patients and their families. Eventually, single rooms became the norm in many public hospitals.

We also saw the RWH unit bring outpatient and in-patient services side by side. This facilitated continuity of oncology care for doctors and patients, dramatically improving our outpatient services, thus enhancing the patient experience.

During this time, the number of female doctors entering gynae-oncology was slowly increasing and, as in O&G generally, the need for more women in gynae-oncology was long overdue.

How did you manage to prioritise family and professional life?
Honestly, with difficulty. The generations who have followed me have been much more balanced in

Prof Quinn in Italy during the Giro d'Italia.

their approach to work and personal life. The hours we worked were long. It was great for clinical and surgical skills, but it came at a cost. Safe working hours, part-time training and job sharing now challenge the attainment of surgical skills, but they have definitely changed medicine's working culture in a positive way.

What have been your career highlights?

Running the New York and London marathons as fundraisers, and climbing Mt Pisco in Peru with my son, were absolute personal highlights.

Professionally, highlights of my career would be: my time as Director of Oncology at RWH; co-founding the Asia-Oceania Research Organisation in Genital Infection and Neoplasia (AOGIN) and the Australia New Zealand Gynaecological Oncology Group (ANZGOG); being honoured as Victorian of the Year, subsequently with an AM; and my current role as President of IGCS.

How have you sustained your career?

Collaborating with colleagues, networking with others in leadership roles, identifying, learning from and sharing with mentors, as well as engaging in regular exercise, have all been instrumental in my career.

What do you see for the future of RANZCOG?

The core mission and vision of the College is the education and training of O&Gs in Australia and New Zealand. This should remain the foundation of the College.

Leadership training and mentoring is a much needed investment by the College. Every new trainee should have a designated mentor.

Do you see yourself as a leader?

Absolutely. Being a medical specialist demands this. Leadership provides such a great platform to create change, which in my areas of clinical practice, have led to enormous improvements in women's health.

What has been your leadership vision?

My current vision is about commitment to improving outcomes for women with gynae-oncological cancers globally. To do this well, leaders need to communicate their vision, be passionate, be effective decision-makers, be receptive to criticism, and, most importantly, maintain integrity.

Do you see yourself as a feminist?

Yes. We all need to work towards gender equality and we need more women in leadership. As part of the IGCS commitment to addressing gender inequality, we have committed to achieving 50:50 gender representation on our board by 2022.

What do you see as the challenges for current trainees?

Academic medicine remains very under-valued in Australia, particularly within O&G. This needs to change for the future status of the specialty.

As seen in the US, managed healthcare is likely to become a feature of private healthcare in Australia. This will challenge and threaten the private practice landscape for specialists, especially obstetric practice.

What three words best describe your life?

A fulfilling, fortunate and fertile professional career.

Prof Quinn is available for contact from centres or individuals interested in supporting gynae-oncology training and services in low-income developing countries.

Subspecialty training and practice within RANZCOG

RANZCOG currently has five recognised fields of subspecialty practice:

- Gynaecological Oncology (CGO)
- Maternal and Fetal Medicine (CMFM)
- Obstetrical and Gynaecological Ultrasound (COGU)
- Reproductive Endocrinology and Infertility (CREI)
- Urogynaecology (CU)

The foundation of the five subspecialties were laid in the late 1980s. In 1989, eight CGO trainees and four CU trainees held the first RANZCOG-recognised specialty trainee posts, followed later by the first specialty examinations (CGO). From these examinations, three specialists were the first recipients of non-grandfathered specialty qualifications.

In the last decade, subspecialty trainee intake has remained relatively stable, with first year trainees numbering 13 to 24, and little variation in gender intake (70% females, 30% males).

In 2018, females represent 69% of subspecialty trainees, with 35% engaged in CMFM training, 23% in CREI training, and 17% in CGO training. Among subspecialty consultants, females represent 46% of specialists, with the current majority engaged in CREI (26%), CMFM (24%) and COGU (21%).

Editorial

Dr Gillian Gibson
MBChB, BSc(Hons), MRCOG, FRANZCOG
Auckland District Health Board, NZ

Worldwide, 40–50 million abortions occur annually. Nearly half of these abortions are performed unsafely, with an estimated 50,000 deaths a year as a result.[1] Abortion-related deaths are more frequent in countries with restrictive abortion laws (34 deaths per 100,000 births), than in countries with less restrictive laws (one or fewer per 100,000 births).[2] Access to abortion care is highly variable worldwide and, in many countries, it is illegal regardless of women's circumstances. On May 25, Ireland, a country with one of the strictest regimes in the western world, will hold a historic referendum on repealing the constitutional ban on abortion. Closer to home, both New Zealand and Queensland abortion legislation is under review.

Australian women are crossing borders to have abortions not available to them in their own state. The variation in laws governing abortion between states and territories of Australia creates inequity of access and variable service provision. Legal confusion reigns, with a different test for when an abortion can be performed in each jurisdiction.[3]

Abortion has been decriminalised in Victoria, Tasmania and the Australian Capital Territory, but remains illegal in Queensland, the state with the most restrictive criteria.

The newly elected New Zealand Labour government has asked the New Zealand Law Commission to review the criminal aspects of abortion, the grounds for abortion and the process for receiving abortion services.[4] The legislation has been unchallenged for 40 years, despite becoming outdated, as medical evidence and public opinion have moved forward.

The College provided submissions to the Queensland Law Reform Commission and the New Zealand Law Commission this year. RANZCOG's position has been uncompromising, stating 'a strong belief that termination of pregnancy should not be a criminal offence, strongly opposing the introduction of specified, legislated grounds to be met for termination to be considered lawful'.[5]

This issue of *O&G Magazine* features an in-depth discussion of abortion law and the argument for abortion to shift jurisdiction from justice to health. The issues surrounding abortion are further explored with articles on history, conscientious objection and the challenge of abortion at periviable gestations. Guidance is provided for abortion care, with the emphasis on accessible and safe services, including prevention of future unintended pregnancies.

References

1. World Health Organization Factsheet. Preventing Unsafe Abortion. 19 February 2018.
2. Unsafe abortion: unnecessary maternal mortality. Available from: www.researchgate.net/publication/26677181_Unsafe_Abortion_Unnecessary_Maternal_Mortality [accessed May 07 2018].
3. Queensland Law Reform Commission. Review of termination of pregnancy laws – RANZCOG response. February 2018.
4. Abortion Law Reform. http://abortionlaw.lawcom.govt.nz.
5. Dickinson J. Confusion, inequity and inconsistency: Abortion in Australia. *ANZJOG* 2015;55(2):105.

Advocacy for abortion

Dr Rudy Lopes
MBBS, FRANZCOG

Michelle Thompson
BBus, MBA, GAICD
CEO, Marie Stopes Australia

In March 2018, the US-based Guttmacher Institute released its global report on abortion progress and access.[1] The report found that of all abortions performed globally, 55 per cent are safe, meaning they are performed using recommended methods and appropriately trained staff. While it may be heartening to know that more than half of abortions performed worldwide are safe, there are still an estimated 25 million that are not.

The majority of unsafe abortions are, according to the Guttmacher Institute, performed in developing nations, where there may be highly restrictive laws and/or lack of access to adequate health services. However, even in countries where there are more liberal regulations towards abortion, there continues to be a slow 'chipping away' at access, driven by predominantly ideological forces.

Abortion has always invoked strong feelings. In most countries, it is considered taboo, subject to criminal proceedings and constant political and social debate. In our region, the procedure is still in the Crimes Act in Queensland, South Australia, New South Wales and New Zealand.

With such controversy surrounding abortion, one could be forgiven for thinking it is a rare occurrence. It is, however, a procedure that will be required by 35 out of every 1000 women of reproductive age.

When it comes to championing safe access to abortion, the role of the clinician, particularly, the O&G, is key. It is this role that has led to the development and application of clinical guidelines, standards and continuous improvement in the training and development of health professionals working in abortion care. This role is broadening beyond clinical and developing into the area of advocacy; a natural evolution given the clinician is in a unique position to see how stigma, law and ideology impact on women seeking an abortion.

Clinician-led advocacy

Successful advocacy requires two essential components: being a respected authority and providing supporting evidence. Doctors are considered one of the most trusted professions. According to the *British Medical Journal*, they are considered the third most trustworthy profession in Australia, after nurses and pharmacists. When it comes to women's health, O&Gs are among the most trusted voices. They are also in a unique position to provide supporting evidence for advocacy efforts. This evidence can be research or more informal methods such as storytelling.

Dr Willie Parker, an O&G from South Carolina, is arguably one of the most well-known clinicians who has taken a lead role in advocating for abortion access and reform. A devout Christian, Parker performs abortions in a number of US states, where access is being reduced through ideologically driven, restrictive legislation. Like many clinicians who perform abortions, Parker knows that each of his patients has experienced judgement, stigma and shame to get to his clinic. 'By the time a woman arrives at an abortion clinic and places herself in my care,' writes Parker in his autobiography, Life's Work: A Moral Argument for Choice, 'she has faced a world of judgement and found that everyone – her boyfriend, her own mother, her pastor, her best friend – has something to say.'[4] Parker uses storytelling to build empathy for the women he sees, while at the same time, employing scientific facts to dispel myths that influence poor policy on abortion.

Australia also has advocate clinicians for abortion reform: Prof Caroline de Costa led the successful effort to bring RU486 into Australia; Dr Kirsten Black and Dr Paddy Moore are at the forefront of advocating for better abortion training for budding clinicians; and Dr Philip Goldstone has strongly advocated for the establishment of safe access zones outside abortion clinics.

The move into advocacy

The decision to move into advocacy by a clinician is one that is generally driven by their professional and personal experiences.

Dr Rudy Lopes is an experienced O&G who, until recently, was working in contraception and family planning services in the public and private sectors. He has decided to take on a greater role in abortion advocacy. He will be developing his interest in advocating for equitable and universal access to contraception and family planning services for women worldwide.

Dr Lopes' story

I've always had an interest in contraception and family planning service provision throughout my residency and time in specialist training. After more than 13 years as a consultant in public and private practice, I took these services for granted in a developed country such as Australia. However, I was brought back to earth when I read an ABC article[5] about a young woman who fell pregnant and decided to have an abortion, a procedure that is banned in Nigeria. She went to see a traditional 'healer', who prescribed a cocktail of traditional medicine, which included spirits, pepper, bark and unnamed herbs, in order to induce a miscarriage. Unfortunately, this failed and she had to pay for an unsafe abortion performed literally in a backyard. She then started haemorrhaging, likely from an incomplete, septic abortion, and was hospitalised. She was lucky to survive. The article goes on to say that 1.25 million illegal abortion procedures are performed in Nigeria annually, and an estimated 30,000–50,000 women die from the procedure. Of those who survive, up to 40 per cent go on to have long-term complications, such as infertility and chronic pain.[5]

The ABC article reports the social complications of having an abortion in Nigeria. This young woman was ostracised from her socially conservative community and forced to work in the sex industry in order to pay off her hospital bills. She had to give up her dreams of studying to be a journalist. Some women who are unable to access a timely abortion are forced to work in brothels, often with their child.[5] It's a sad and demoralising picture, which could have been prevented with equitable access to contraception and a reasonable level of school-based sex education.

Unfortunately, Nigeria is not alone in its stance against contraception and abortion. Unsafe abortion has been described as, 'one of the most neglected sexual and reproductive health problems in the world today,'[6] and is a major public health crisis in many developing countries. The World Health Organization (WHO) defines unsafe abortion as a procedure that results in complications or death due to inadequate skills of the provider, harmful techniques and/or unsanitary conditions.

There are a number of nations that are, through legislation and regulation, driving women to seek unsafe abortion. The Timorese Government is considering draft legislation seeking to ban contraception.[7] Unplanned pregnancy continues to be problematic in Latin America, particularly among the indigenous, rural and remote populations. In Haiti, Médecins Sans Frontières (MSF) reports high rates of complications with unsafe abortion, requiring hospital treatment.[8] A pre-teen girl in India gave birth after being raped.[9] A teenage rape victim in Paraguay died giving birth to a macrosomic infant, possibly due to a pulmonary or amniotic fluid embolism.[10] Maternal death is a possible consequence of unintended pregnancy.

As clinicians, we should be at the forefront of advocating for equitable access. The Guttmacher Institute specifically references the power that reform-minded champions have in changing public opinions. National associations of O&Gs and medical councils have used evidence on high maternal mortality linked to unsafe abortion to advocate for reform.

I have joined the fight against these restrictive policies, and to this end, have enrolled in a Masters in Public Health, in order to gain more knowledge and become more effective in my role as an advocate for women in underprivileged areas. If we can look after the reproductive rights of women throughout the world, this will improve the current rates of morbidity and mortality caused by lack of contraception and access to safe family planning services. If I can stop one unnecessary maternal death from unsafe abortion or lack of contraception, then I will have done something worthwhile. As individuals, clinicians are powerful advocates. It is, however, when we act collectively that our power is amplified.

Across the globe, access to safe abortion is unfinished business, even in developed nations such as Australia and New Zealand. Advocacy requires a chorus of voices from the medical community. I became a doctor because I wanted to help people. Women need access to adequate contraception and safe family planning services. Yet, in many cases, women are unable to speak up about their experiences in being denied this access. It is our responsibility, as carers, to speak on their behalf, to advocate for them, and to use our influence to advance their cause. We must be the voice for change on the issue of access to safe termination of pregnancy.

Find out how you can get involved in abortion advocacy: www.mariestopes.org.au/advocacy-policy.

References

1. Guttmacher Institute. Abortion Worldwide 2017: Uneven Progress & Unequal Access. New York 2018.
2. Luft LM. The essential role of physician as advocate: how and why we pass it on. *Canadian Medical Education Journal* 2017 June 30;8(3):e109-e116.
3. Kmietovicz Z. R.E.S.P.E.C.T – why doctors are still getting enough of it. *BMJ* 2002 January 2; Vol 324. 11p.
4. Parker W. Life's Work: A Moral Argument for Choice. Kindle Edition. New York. Simon & Schuster, 2017.
5. Cooley D. Quacks are killing our women: Nigeria's abortion ban pushes women to drastic measures. ABC. 2018 February. Available from: www.abc.net.au/news/2018-02-10/nigerias-abortion-ban-pushes-women-to-drastic-measures/9416164.
6. Grimes DA, Benson J, et al. Unsafe abortion: The preventable pandemic. *Lancet* 2006;368(9550):1908-1919.
7. Barker A. East Timor considering contraceptives ban for unmarried women and girls. ABC. 2017 December. Available from: www.abc.net.au/news/2017-12-12/east-timor-might-ban-contraceptives-for-unmarried-women-girls/9247490.
8. Charles J. Unsafe abortions: Haiti's abortion crisis. Miami Herald. 2013 November. Available from: www.miamiherald.com/news/nation-world/world/americas/haiti/article1957812.html.
9. 11-year-old girl gives birth after alleged gang rape by six men. News Ltd. 2018 March. Available from: www.news.com.au/lifestyle/real-life/news-life/11yearold-girl-gives-birth-after-alleged-gang-rape-by-six-men/news-story/ec927e24fef9128fa5256e5c585330fc.
10. Rape victim, 14, dies in childbirth in Paraguay. Nine News Digital. 2018 March. Available from: www.9news.com.au/national/2018/03/23/13/23/rape-victim-14-dies-in-childbirth-in-paraguay?app=applenews.
11. Ganatra B, Tunçalp O, et al. From concept to measurement: operationalizing WHO's definition of unsafe abortion. WHO Online Bulletin. 2014 Available from: http://dx.doi.org/10.2471/BLT.14.136333.

The unfinished business of abortion law reform

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In 2017, a young Sydney woman was convicted of the crime of procuring her own abortion. She had sourced mifepristone on the internet in an attempt to end an unwanted pregnancy at home.[1] In Cairns, in 2010, a young woman was also prosecuted for having taken abortion drugs she had obtained from overseas. In the Cairns case, the woman was eventually acquitted by a jury, but only after a protracted committal and trial process spanning many months.[2]

These cases are a stark reminder of the unsatisfactory state of abortion law in Australia and New Zealand. While six of the eight Australian jurisdictions have amended their laws since the 1970s, abortion remains in the criminal law across much of the country, as well as in New Zealand. Each jurisdiction has a different test for when abortion can be lawfully performed. The result is that abortion remains in a 'grey zone' as one of the most commonly performed procedures, but not part of mainstream gynaecological practice in the public health system, with the taint of criminality still lingering in the background.

Origins of abortion law

Australia and New Zealand inherited many of their laws from the UK. The early criminal law in both countries incorporated the provisions of the UK Offences Against the Person Act 1861. The law made abortion a crime, both for those performing it and for women undergoing it. Since this was the era of 'backyard abortions', there was perhaps reason to deter abortion providers, many of whom were unskilled and unscrupulous. However, while there may have been justification for these laws in the first place, this does not explain why their effects are still being felt in former British colonies, long after the UK reformed its own laws to bring them into line with modern medical practice.[3]

Law reform in the last 50 years

Because the criminal law is a State rather than a Federal power under the Australian Constitution, each of the six Australian states and two territories has its own criminal code, and each has dealt with the politics of abortion law reform in its own way. South Australia was the first to reform its abortion laws in 1969. Five other Australian jurisdictions – the Northern Territory (1974, 2006 and 2017), Western Australia (1998), the ACT (2002), Victoria (2008) and Tasmania (2013) – and New Zealand (1977), have since passed legislation to make abortion lawful in some circumstances. However, no two jurisdictions have adopted the same regulatory regime and each has a different test for when abortion can be performed lawfully. Table 1 provides a summary of the different laws across all jurisdictions and highlights the extent of the inconsistency.

In the abortion laws passed in Australia and New Zealand over the last 50 years, the key features are:

- Whether abortion can be lawfully performed based on the consent of the woman alone.
- If additional criteria must be satisfied, what are they? (For example, certification by a doctor that the abortion is 'appropriate' or is necessary to prevent risk to the life or health of the woman.)
- Are there additional criteria to be met for lawful late terminations? If so, what are they and from what gestational age do they apply?
- Does the law specifically permit health practitioners to refuse to perform abortions based on a right of conscientious objection and, if so, must they refer women elsewhere?
- Does the law establish 'safe access zones' around clinics in order to prevent women seeking abortion services from being harassed?

The test for lawful abortion

It is striking that only three of the jurisdictions reviewed here, Victoria, Tasmania and the ACT, recognise the right of a woman to make her own decision about whether to terminate a pregnancy, and even then gestational limits apply in two out of the three jurisdictions. In all the other jurisdictions, the decision-maker is the doctor, and abortions can only be lawfully performed if the doctor forms the view that the relevant legal criteria are met. In some circumstances, two doctors must certify that the termination is appropriate,[4] or else two members of a government-appointed panel must give approval.[5] In this era of patient autonomy, it is difficult to imagine this approach being tolerated in relation to any other medical procedure.

Regulation of late-term abortion

There are also widely different approaches to the regulation of late termination, including the stage of the pregnancy from which additional legal requirements should apply. The legislation in Victoria, Western Australia and Tasmania impose more onerous requirements for lawful termination from 24 weeks, 20 weeks and 16 weeks respectively. South Australia and the Northern Territory prohibit terminations after 28 weeks and 23 weeks

respectively, except where necessary to save the woman's life. In other jurisdictions, including New Zealand, there are no specific legal requirements for late terminations, but in these places (with the exception of the ACT), abortion at any stage of the pregnancy is potentially a criminal offence.

New South Wales and Queensland

New South Wales and Queensland have so far resisted all calls for abortion law reform, and still retain in their criminal law the original 19th century UK offences carried over at the time of Federation. These laws have rarely been used. In the small number of cases that have gone to court, judges have developed the common law principle that abortion can be lawfully performed, in New South Wales and Queensland, where a doctor reasonably believes the termination is necessary to prevent a serious risk to the woman's life or physical or mental health.[6] However, the application of this test depends upon the judgment of the court in each case, and therefore does not provide a certain or secure basis for determining when abortion is or is not lawful. It also provides no defence for a woman seeking to procure her own termination, as the recent prosecutions in both New South Wales and Queensland have demonstrated.

Right of conscientious objection

All the jurisdictions reviewed here, with the exception of New South Wales and Queensland, recognise the right of conscientious objection on the part of

Table 1. Summary of abortion laws in Australia and New Zealand.**

	Australia								New Zealand
	Australian Capital Territory	Victoria	Tasmania	Northern Territory	Western Australia	South Australia	New South Wales	Queensland	
Termination lawful on request	✓	✓ (up to 24 weeks)	✓ (up to 16 weeks)	x	x	x	x	x	x
Termination lawful if doctor(s) satisfied of certain matters	not applicable	✓ (up to 24 weeks, if appropriate in all the circumstances)	✓ (up to 16 weeks, if risk to physical or mental health)	✓ (up to 23 weeks, if appropriate in all the circumstances, or if emergency)	✓ (up to 20 weeks for most grounds; after 20 weeks, if woman or fetus has severe medical condition)	✓ (risk to life or health, fetal abnormality or emergency)	✓ (risk to life or health: common law)	✓ (risk to life or health: common law)	✓ (up to 20 weeks for most grounds; after 20 weeks to save life or prevent serious permanent injury)
More than one doctor or a committee must be satisfied	not applicable	✓ (after 24 weeks, at least 2 doctors)	✓ (after 18 weeks, 2 doctors, including a specialist)	✓ (after 14 weeks and up to 23 weeks, at least 2 suitably qualified doctors, except in emergency)	✓ (after 20 weeks, at least 2 doctors from a panel)	✓ (2 doctors, except in emergency)	x	x	✓ (2 doctors, except in emergency)
Offences for unlawful termination	✓ (but not for a doctor)	✓ (but not for a doctor or other qualified person, or the woman)	✓ (but not for a doctor or the woman)	✓ (but not for a doctor or other qualified person, or the woman)	✓ (but not for a doctor)	✓	✓	✓	✓
Conscientious objection by doctors recognised	✓	✓ (except in emergency)	✓ (except in emergency)	✓ (except in emergency)	✓	✓ (except in emergency)	x	x	✓
Doctors who object to refer women to other provider	x	✓	✓	✓	x	x	x	x	x
Counselling					(referral to counselling to be offered)				(to be advised of right to seek counselling)
Safe access zones established	✓	✓	✓	✓	x	x	x	x	x

** Taken from the Queensland Law Reform Commission's Consultation Paper Review of Termination of Pregnancy Laws, December 2017, Appendix B.

health practitioners who have a moral or religious opposition to abortion, but only three (Victoria, Tasmania and the Northern Territory) require referral of the patient to another health practitioner who does not share the same objection. This raises concern that the exercise of conscientious objection may limit access to abortion services in practice, particularly in rural and remote areas, where healthcare options are limited.

Safe access zones

The issue of safe access zones around premises providing abortion services remains an issue of controversy. Only four Australian jurisdictions have established such zones, and there is currently a case before the High Court challenging the constitutional validity of these provisions, reportedly based on alleged infringement of an implied right of freedom of political communication.[7]

Australian Commonwealth law

Adding to this tangled legal web are Commonwealth laws governing health funding and the regulation of therapeutic goods. The listing of mifepristone and misoprostol under the Australian Pharmaceutical Benefits Scheme, in 2013, greatly increased the affordability of these drugs. However, the provision of information about the availability of medical abortion is highly restricted as a result of provisions in the Therapeutic Goods Advertising Code, which specifically prohibit the advertising of drugs that have an 'abortifacient action'.[8] One can only wonder at the policy justification for preventing women from receiving full and detailed information about their reproductive health options.

Abortion law reform is needed

The patchwork of different legal regulation across nine different jurisdictions in Australia and New Zealand is confusing and irrational. Doctors attempting to navigate this terrain could be forgiven for feeling nervous about exposing themselves to the risk of criminal liability if they perform abortions. Even though prosecutions are extremely rare, it is unsatisfactory, in 2018, that one of the most commonly performed procedures should remain subject to complex and uncertain legal regulation, as well as the threat of criminality in some places.

Majority public opinion has consistently been shown to favour lawful access to abortion.[9] It is time for the law in Australia and New Zealand to be brought into alignment with public opinion and accepted medical practice, so that abortion can become a full part of mainstream gynaecological care.

References

1. Director of Public Prosecutions (NSW) v Lasuladu [2017] NSWLC 11.
2. R v Brennan & Leach [2010] QDC 329.
3. Abortion Act 1967 (UK).
4. This is the case in South Australia and New Zealand, and for later term abortions in Victoria, Tasmania and the Northern Territory.
5. This is required in Western Australia.
6. R. v. Wald (1971) 3 DCR (NSW) 25; R v Bayliss and Cullen (1986) 8 Qld Lawyer Reps 8; CES & Anor v. Superclinics (Australia) Pty Ltd & Ors (1995) 38 NSWLR 47; R v. Sood [2006] NSWSC 1141.
7. www.theage.com.au/national/victoria/prolifers-draw-inspiration-from-bob-brown-in-defence-of-abortion-clinic-charges-20171028-gza36m.html.
8. Therapeutic Goods Advertising Code 2015 (Cth), Appendix 6, Part 1.
9. For a summary of recent surveys of community attitudes to abortion, see the Queensland Law Reform Commission Consultation Paper Review of Termination of Pregnancy Laws, December 2017, pp27-28.

NZ's abortion law: time for change

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It is accepted by people on both sides of the abortion debate that there is a marked difference between the legislation and the way abortion is practised in New Zealand. The Contraception, Sterilisation and Abortion (CSA) Act and the abortion grounds in s187A of the Crimes Act were enacted in 1977 and have not been revised since. They are now outdated and no longer fit for purpose. The Abortion Supervisory Committee, whose job it is to oversee abortion in New Zealand, would be 'concerned if another decade was to pass and it was still required to govern under such old and outdated language,' fearing for the 'medical professionals [who] would be required to operate around processes and language that, in many places, is no longer applicable or practical in our society today.'

The law in New Zealand

Access to abortion is granted to most women in New Zealand purely through 'benevolent interpretation' of the law. The act of terminating a pregnancy in New Zealand is a crime unless two consultants certify that one of the grounds for a termination applies. If the pregnancy is of less than 20 weeks gestation, it may be lawfully terminated on one of five grounds:

- A serious danger to the life or the physical or mental health of the woman
- A substantial risk that the child will be severely handicapped
- A pregnancy resulting from incest
- A pregnancy resulting from an offence under section 131 of the Crimes Act
- The pregnant woman is severely subnormal

If the pregnancy is more than 20 weeks gestation, the person performing the abortion must believe it is necessary to save the life of the pregnant woman, or prevent serious permanent injury to her physical or mental health. Abortions after 20 weeks make up a minuscule fraction of the total number of abortions performed in New Zealand every year. In 2016, just 76 out of 12,823 abortions took place after 20 weeks, or less than 0.006 per cent. Most abortions are performed on the first ground, in particular, that the certifying consultants believe the pregnancy poses a serious danger to the women's mental health.

The reality in New Zealand

It seems that this mental health ground is liberally interpreted. The statistics are telling. In 2016, of the 12,823 abortions performed, 12,437 were on the grounds of danger to the mental health of the mother.[1] A further 223 terminations were performed on mental health grounds in combination with other grounds, such as fetal anomaly or physical danger to the health of the mother, totalling nearly 99 per cent of abortions in New Zealand. In 2008, in a case brought by Right to Life New Zealand against the Abortion Supervisory Committee, the High Court commented that the high number of women receiving terminations on this ground suggested that 'certifying consultants collectively are ... employing the mental health ground in much more liberal fashion than the legislature intended.' While such observations might call into question the lawfulness of many abortions, the Courts have consistently held that the regulatory framework put in place leaves it to doctors to determine whether one of the abortion grounds exists. It is a medical decision and the courts will not 'question a decision actually made in a particular case'.

Nonetheless, the large number of women seeking an abortion on mental health grounds calls into question the suitability of the current law. The liberal interpretation of this ground puts doctors performing abortions at risk of prosecution for a serious criminal offence. That risk is greatly increased if there is a slight political shift, resulting in a tightening up in the application of the abortion grounds, making access to abortion much harder. Doctors and women are both victims when abortion is illegal. Globally, 21.6 million women experience unsafe abortion a year and 47,000 of these women die from complications.

Access to abortion

The CSA Act sets out a detailed and lengthy procedure for obtaining and performing an abortion in New Zealand, involving multiple visits to professionals and consultants who must agree that one of the grounds to perform a termination exists. This process results in delays for women seeking abortions. Ashton, McNeill and Silva[7] found that, while terminations overwhelmingly occur within the first trimester, New Zealand women consistently access terminations later in the first trimester than other developed countries, which increases the risk of complications. This study found New Zealand women had to wait an average of 24.9 days from first contact with the health system and the date of the termination.

The process also creates access problems. Abortion is not equally available to all women in

New Zealand. In 2000, the Abortion Supervisory Committee reported that the laws 'are not being applied consistently throughout the country.'[3] Travel times and difficulties locating two certifying consultants may be contributing to late access to terminations. In 2016, there were only 162 certifying consultants in New Zealand. Living in rural areas makes it much harder to get certifying appointments. These difficulties 'make [the law] inequitable for poorer women, for women in rural areas, to access the services they need.'[5] The Abortion Supervisory Committee's Annual Report, released in early 2018, draws further attention to the 'unacceptable and untenable' fact that Auckland, New Zealand's largest centre and a sprawling geographical area, has only one main public service.[1]

Outdated legislation

The law has not kept up with medical advances in New Zealand. The legislation was enacted to prevent the unnecessary death and suffering of women unable to carry a pregnancy. In 1861, abortion was a 'technically demanding, dangerous surgical procedure'. Medically, it was sensible to restrict it 'to only the most compelling of cases'.[9] By 1977, when our current legislation was enacted, abortion was safer, but still carried significant risks. It required a surgical procedure and had to be performed in a licensed institution. Today, abortions are much safer and can be performed without any invasive surgical procedure at all, but the law remains stagnant.

In its most recent report, the Abortion Supervisory Committee reiterates that it has made calls for changes to be made to the CSA Act, to bring it in line with modern healthcare delivery and reflect advances in technology. The Committee has emphasised old and unhelpful language in the legislation: throughout, it refers to doctors as 'he' and uses terms like the 'woman's own doctor', which no longer reflects modern general practice. This is also demonstrated in the reference to a 'severely subnormal' woman, a term which has been removed from other parts of our statute books, due to it being outdated and offensive.[8]

The law governing abortion is changing in many jurisdictions. It has been removed from the criminal legislation in a number of Australian states, and Bills purporting to do the same have been introduced in recent years in other states and the UK. These jurisdictions attempt to treat abortion as a medical issue, albeit one that is subject to special regulation. The law must evolve to recognise the development in the medical profession and the changes in social attitude that sees abortion as a private medical decision to be made between a woman and her doctor. The issue has now been referred to the New Zealand Law Commission, presenting the first real opportunity for the legislation to be reviewed and bring law into line with practice.

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References

1. Abortion Supervisory Committee. Report of the Abortion Supervisory Committee 2017. March 2017: 1-29.
2. Convention on the Elimination of All Forms of Discrimination Against Women. Concluding observations of the Committee on the elimination of discrimination against women. 2012 August:1-12.
3. Right To Life New Zealand Inc v The Abortion Supervisory Committee [2008] 2 NZLR 825 (HC).
4. Right To Life New Zealand Inc v The Abortion Supervisory Committee [2012] NZSC 68 at [40].
5. O'Connor S. A precarious position: The state of sbortion law in New Zealand. Salient [Internet]. 2017 August [cited 2018 March]. [about 1 p.] Available from http://salient.org.nz/2017/08/a-precarious-position-the-state-of-abortion-law-in-new-zealand/.
6. World Health Organization. Unsafe abortion: global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008. 2011: 1-66.
7. Ashton T, McNeill R, Silva M. Ladies in waiting: the timeliness of first trimester services in New Zealand. *Reprod Health*. 2010;7:19.
8. Abortion Supervisory Committee. Report of the Abortion Supervisory Committee 2016. March 2016:1-31.
9. Sheldon S. The decriminalisation of abortion: An argument for modernisation. *OJLS* 2016; 36(2): 334-365.
10. Sood S. Some operative and postoperative hazards of legal termination of pregnancy. *BMJ* 1971; 4:270.

Early medical abortion: reflections on current practice

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Mifepristone was first licensed for abortion in France and China in 1988. In the last 30 years, medical abortion has globally become an established, safe and straightforward method for pregnancies of less than nine weeks gestation. It is now recommended by the Royal College of Obstetricians and Gynaecologists as the method of choice for women up to nine weeks gestation.[1-6]

The reality of providing medical abortion for women, however, is a more complex matter. Abortion services are contextualised by the specific and, at times, changing abortion laws in each country and state. These laws, in turn, are determined and maintained by each jurisdiction's specific gendered social and political histories, practices and attitudes.[7]

In Australia and New Zealand, this context continues to affect who can provide medical abortions, the models of care adopted, the ongoing struggle to provide affordable and accessible care to all women, and the level to which medical abortion is accepted as a normal and important part of women's healthcare.

Within the context of these histories and challenges, this article will attempt to guide you through the process of providing a medical abortion as a health practitioner. It also hopes to be a 'call to arms' for readers to reflect on what they want to do as an individual practitioner, and as a broader group of women's health practitioners, to help make medical abortion affordable, accessible and accepted. All health providers must decide about their practice of abortion care with respect to their own personal belief system. However, it is incumbent on us all to understand the services available and guide and support women in their decision-making.

Early medical abortion

Early medical abortion involves the use of two medications, mifepristone (200mg oral) and misoprostol (800µg buccal), in pregnancies of less than 63 days gestation. Misoprostol is given 36–48 hours (Australia) and 24–48 hours (New Zealand) after the mifepristone. Both countries strongly recommend the site of the pregnancy and the gestation is confirmed by ultrasound or, if not available, that every reasonable effort be made to exclude an ectopic pregnancy.

Mifepristone is a synthetic progesterone receptor antagonist, that affects endometrial progesterone receptors, disrupting the attachment of a developing pregnancy. Mifepristone also sensitises the myometrium to contraction-inducing prostaglandin, and softens and dilates the cervix. Misoprostol is a synthetic analogue of prostaglandin E1 and causes uterine contraction and cervical dilatation. Misoprostol can also be given vaginally, which is sometimes worth considering in women as an alternative mode of delivery.

Medical abortion in Australia and New Zealand

Abortion laws are specific to each country and, in the case of Australia, each state or territory.[8,9] While there has been significant law reform over the past decade, abortion remains in the criminal code in Queensland and New South Wales. Current laws have a specific and unintended impact on the provision of medical abortion. New Zealand, the ACT, South Australia and the Northern Territory require that all abortion services be delivered in a facility licensed to carry out abortions. While individual practitioners and health centres have used creative medical 'gymnastics' to make services accessible to women, it has remained a challenge for many women to take misoprostol at home. The laws have also made it difficult to properly service rural and remote communities (particularly remote Indigenous communities), and for GPs to actively take up the provision of medical abortions in these jurisdictions.

The long, drawn-out process of registering mifepristone in Australia has been well-documented and is essential reading to fully understand the political and social forces at play.[10]

In Australia and New Zealand, the number of doctors becoming certified prescribers of mifepristone remains comparatively low. Anecdotally, in Australia, we know there are only a small group of registered prescribers performing medical abortions outside of dedicated abortion services. Even in Victoria, after the 2008 law reforms, medical abortions have largely remained the domain of private abortion centres.

GPs have been very slow to take up prescribing. The reasons for this are numerous. Many GPs have spoken of their fear of being targeted as the 'abortion doctor' in their communities, or of being ostracised if they take up prescribing, or indeed, being overwhelmed by a 'tsunami' of women wanting abortions. Others wanting to provide medical abortions, particularly in smaller or regional communities, have struggled to find pharmacists willing to provide the medications. For complex reasons, partly due to the fact that Australia has never had a coordinated, central public health approach to abortion,[10] and partly because the private sector needs to run a business (where the majority of abortions are provided), medical abortions have, until recently, remained the same cost as surgical abortions (A$400–500 after a rebate, double this for women who do not have citizenship entitlements).

The specific history of the provision of medical abortion reminds us of an important lesson: that all positive change takes the combined and sustained efforts of many individuals and groups. Why can't medical abortions be affordable and readily available for any woman seeking one, no matter where she lives?

Become a provider

To become a certified prescriber in Australia, complete an online course via the Marie Stopes website (https://www.ms2step.com.au). There is no cost and it takes 4–6 hours. Individuals with FRANZCOG or DRANZCOG Advanced certificates will get immediate certification on registering and are not required to do the training.

The Marie Stopes MS-2 Step website is excellent and the training is recommended for all healthcare providers wanting to offer medical abortions as part of their practice. The website provides good resources for practitioners providing medical abortions and women seeking one. You can also access a list of registered pharmacies by postcode. If there are no pharmacists in your area, consider visiting some in person to encourage them to register. Visiting your local ultrasound service can be very important, to check they will communicate ultrasound findings in an appropriate manner and to accurately appreciate costs involved. There is now a closed Facebook page for medical abortion providers to discuss challenging cases, seek advice and get support.

In New Zealand, the majority of abortions are performed in the public system. Doctors interested in prescribing should contact the Abortion Providers Group Aotearoa New Zealand (www.apganz.org.nz). Another important website for women and providers is www.abortion.org.nz. This site lists all providers and their services.

Important steps in providing best practice medical abortion care

The following three tables outline recommended best practice abortion care, combined with the author's own reflections, having provided medical abortions for many years in different work environments (a private abortion provider, a publicly funded young person's health centre, and currently, at the Austin Hospital's Family Planning Clinic).

The few medical contraindications to having a medical abortion are summarised in Table 1.

Table 1. A summary of contraindications and other factors to consider.

Medical abortion: Medical contraindications	Medical abortion: Precautions and warnings
No confirmation of pregnancy/uncertain of gestational age	Severe cardiovascular disease
Ectopic pregnancy	Renal or liver failure
Known bleeding disorder/ current anticoagulant medication	Malnutrition
Chronic adrenal failure	Multiple uterine scars or history of uterine rupture
Porphyria	Epilepsy
Anaemia (Hb<100g/L)	Heavy smokers
IUCD in-situ	Long-term steroid medication (mifepristone may make steroid less effective and mean that increased doses may be needed)
Known allergy/ hypersensitivity to mifepristone or misoprostol	Breastfeeding
Pregnancy in non-communicating horn of uterus	

Notes

It is important to acknowledge the early role of Istar, the New Zealand not-for-profit pharmaceutical company, formed in 1999 by five doctors for the sole purpose of importing mifepristone from France. At that time, no established pharmaceutical firm was willing to import mifepristone. Istar helped Australia access the drug in those early years and remains the sole supplier of mifepristone in New Zealand.

Women who have had multiple caesarean sections have had no problem with having a medical abortion.

Breastfeeding is listed in the product information, but there are, as yet, limited data, suggesting that the levels of mifepristone in a 200mg dose are very low. In practice, we advise women to continue breastfeeding with mifepristone. We advise women to avoid breastfeeding or express and dispose of the milk for up to 6 hours after misoprostol intake. Misoprostol may cause diarrhoea in the infant.

Uterine didelphys is not a contraindication to medical abortion.

Providing quality care

With respect to abortion delivery in Australia, Baird, in 2015, wrote, 'Countries like ours, have ended up delivering an approach to medical abortion that is overly cautious, highly regulated and medicalised'.[10] Other countries have taken up different models of care and are researching the efficacy of non-medical providers offering medical abortion. It is essential to explore these different models, to reflect on what is worth protecting and developing with each, and to determine the care each woman requires and can readily access.

In Victoria, services are starting to change. Private abortion clinics, such as Marie Stopes, have commenced offering medical abortion via telemedicine (from A$290 with a healthcare card). Family Planning Victoria is now seeing women for medical abortions (A$120 out-of-pocket plus medications; healthcare card holders are bulk-billed). Some public hospitals, (such as the Royal Women's and the Austin in Melbourne), are providing medical abortions to small numbers of women each week

Table 2. Best practice pre-medical abortion care.

Best practice pre-medical abortion care	Recommended practice and lessons learnt
Consultation approach	• Know the specific laws in your jurisdiction. • If you practise in a state that no longer requires you to determine a 'reason', make sure your consultation approach reflects this. It is important to acknowledge difficulties and the particular significance of decision-making for each woman. It is important to ask, specifically, if the woman is clear in her decision-making and to confirm that the decision has been her decision, with no coercion. • Avoid prescriptive ideas that a woman must always have a certain type of support at home. Listen to her specific circumstances and work out a plan that is safe and as supportive as possible.
Confirm pregnancy: intrauterine and gestational age	• BhCG. One BhCG is not unreasonable (approx. 100 at 4 weeks, 1000 at 5 weeks, 10,000 at 6 weeks). Remember that you may not see a gestational sac on a vaginal scan <1,500 IU/L). • Ultrasound scan. If you are referring a woman to another service, you do not need to organise a scan. The service will do a scan as part of the visit. If you are providing the service, you will need to organise the scan yourself.
Contraindications/ precautions or warnings	• See Table 1.
Is medical abortion the best option?	• Discuss surgical options. Ensure that a medical approach is appropriate in each context.
Determine/confirm rhesus status	• Give Rh(D) immunoglobulin to Rh negative (non-sensitised) women in accordance with local protocols. • There is a point-of-care test available to health practitioners. It has a low false negative rate and is considered reliable. • Be sure to include rhesus status and antibodies, if known, if you are a GP referring a woman for a medical abortion.
Consider STI screening	• STI screening and treatment in accordance with surgical abortion; published local guidelines and knowledge of local prevalence.
How to take medications and expected experience	• Bleeding and cramping 1–4 hours after misoprostol ranging from mild to severe. • Bleeding may be very heavy with clots, but will decrease after the gestational sac has passed. • Average bleeding 10–16 days, but can be bleeding on and off until the next period, which will come 4–6 weeks later (with 28-day cycle). • Mild short-term nausea, vomiting, diarrhoea, fever/chills with misoprostol, though relatively uncommon now with buccal or vaginal administration. • Don't underestimate the expected bleeding or pain. This is often documented in feedback as the primary failing on the part of providers of medical abortions. • Consider if the woman won't be able to cope with cramping and heavy bleeding. • Nothing in the vagina for 14 days (tampons/sex/baths/spas/swimming). • General experience is that 90% of women will pass the pregnancy sac 1–4 hours after taking misoprostol. • Make a plan about what to do if there is no bleeding 24 hours after misoprostol. • Occasionally there is some bleeding after mifepristone.
Treatment failure medical abortion	• Ongoing pregnancy rates <0.8%[3,4] (lower with smaller gestational age 0.4%).
Possible complications	• Discuss possibility of requiring further follow up, including surgical evacuation of products. • Curette rate 2–5%.[3,4] With quoted rates nearer 5%, it is possible that a surgical procedure is decided upon, due to over-reporting of retained products, or woman/provider unwilling to wait or try second dose misoprostol. • Haemorrhage requiring a transfusion (0.1%).[3] • Infection (0.1%).[3]

Table 2 continued. Best practice pre-medical abortion care.

Best practice pre-medical abortion care	Recommended practice and lessons learnt
Access to emergency medical care and adequate support	• Make a plan for emergency care. • Is there a hospital less than 1 hours' travel from home? • Lack of telephone access or difficulties communicating easily by phone may mean that a medical abortion is not an option. • Australia: 24-hour MS health nurse (1300 515 883). There is an option online to register a woman, so she will receive timely text follow up and reminder of appointment. • It helps to explain that any level of heavy bleeding in the first hour is normal. However, in the second hour, if still bleeding heavily (2 maxipads/hr)/ unmanageable pain/worried in any way, call the 24-hour service or attend closest hospital as appropriate.
Follow-up	• Most services arrange follow-up consultation at 1–2 weeks. Discuss this and make a plan if the woman cannot make an appointment. • Phone consultation with local BhCG (blood/urine) follow up is another valid approach where face-to-face follow-up is difficult.
Written information and consent	• It is useful to provide written information about process AND a plan for adequate analgesia. • Give one dose of non-steroidal medicine prior to any cramping, repeat this when cramping starts and then use paracetamol/codeine with further non-steroidal medication, in accordance with usual prescribing practices.

Contraception	• Discuss contraception and make a plan (ovulation can occur <2 weeks after medical abortion). You can start:
	  • COCP: as soon as heavy bleeding has settled.
	  • implants and injectables: once bleeding has begun. (Many providers are inserting implants on day of first consult with no ill effect).
	  • IUCDs: once complete medical abortion is confirmed.

Table 3. Best practice post-medical abortion care.

Best practice post medical abortion care	Recommended practice and lessons learnt
Ensure medical abortion is complete	• Depending on resources available and skill set, you may (in addition to a good history) do a follow-up serum BhCG (for example, the day before consultation) or an abdominal/vaginal ultrasound. • Expected BhCG drop: 96.3% day 7–9 and 97.5% day 10–14 (CI 95%).[11] • Urinary BhCG is less helpful as may be positive for up to 4 weeks. • Semi-quantitative BhCG point-of-care tests are available in other countries, but not currently in Australia and NZ. (This would be a very helpful tool to have, making follow up simpler and potentially cheaper).
Has medical abortion failed?	• Surgical evacuation of products of conception or repeat medical abortion if still within gestational criteria. (Experience at the Austin Hospital has been that most women proceed to a surgical procedure after a failed medical abortion).
Managing retained products of conception (RPOC)	• If the woman is well and has no significant ongoing bleeding, most retained products of conception are not an issue and will pass with the next period. • If ongoing bleeding, consider surgical management, or further misoprostol. A surgical evacuation of remaining products will need to be considered if bleeding is heavy, or if anaemic.
Contraception	• Ensure the woman has contraception (see above). • Ensure the woman is not pregnant again if follow-up appointment has been delayed. (At the Austin, we have occasionally seen women present pregnant after a medical abortion 3 weeks prior.)
Review STI screening results	• If positive, it is likely that treatment has already been started. • Check notification and treatment of sexual partners. • Check adequate treatment.

and offering training and support to GPs who would like to provide medical abortions (and IUD insertion) in their practice. In addition, a new central referral service called 1800 My Options has recently been launched by Women's Health Victoria.

New models are also emerging in response to a call from GPs for more collegiality and support in setting up and embedding medical abortion services in their practices. Three services, (the Royal Women's Hospital, Family Planning Victoria and the Centre for Excellence in Rural Sexual Health [CERSH], University of Melbourne), have joined forces to provide a new and innovative approach to medical abortion in rural Victoria. To date, this has involved taking education, resources and support to GPs and nurses in rural areas. An inspiring expansion of affordable access to medical abortions has begun.[10] In a few rural areas, women can now obtain a medical abortion, where the only cost is the medication (A$15–45). Nurse-led and nurse-GP partnerships are becoming the most successful abortion care models.[12,13]

Telemedicine approaches have been available for over a decade and are becoming more well known (the Tabbot Foundation, launched in 2005, costs $250). Home self-administration is also available, through women accessing medical abortions online. Practitioners may have heard about Women on Waves and Women on Web. It is worth knowing more about these groups, so that you can let women know about their services. Increasingly, practitioners may see women who have accessed a medical abortion this way and then present with a complication.

Conclusion

When medical abortions became available in Australia and New Zealand, many of us could see potential to solve the problems of access, affordability and stigma associated with abortion.

Until recently, this had happened only to a small extent. The ground is still 'eggshells' around abortion care services. Yet, the situation will become more solid as practitioners engage in thinking about what role they would like to have. Many GPs, gynaecologists and nurses are doing this and there are now some innovative and exciting models for duplication. Doctors are increasingly no longer the gatekeepers. Women are choosing and accessing medical abortion for themselves.

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References

1. Chen M, Creinin M. Mifepristone with buccal misoprostol for medical abortion: a systematic review. 2015. *Obstetrics and Gynaecology – Family Planning Review*. 0(0): 1-10.
2. Fiala C, Winikoff B, Helström L, Hellborg M. Acceptability of home-use of misoprostol in medical abortion. *Contraception* 2004. Vol 70(5):387-391.
3. Goldstone P, Walker C, Hawtin K. Efficacy and safety of mifepristone-buccal misoprostol for early medical abortion in an Australian clinical setting. *ANZJOG* 2017. 1-6.
4. Goldstone P, Michelson J, Williamson E. Early medical abortion using low dose mifepristone followed by buccal misoprostol: a large Australian observational study. *MJA* 2012. Vol 197:282-286.
5. Women's Health Committee RANZCOG. The use of mifepristone for medical termination of pregnancy. RANZCOG Statement. 2007 (amended 2016). pp1-12.
6. Black K. Some women feel grief after an abortion but there's no evidence of serious mental health issues. April 16 2018. The Conversation: https://theconversation.com/some-women-feel-grief-after-an-abortion-but-theres-no-evidence-of-serious-mental-health-issues-95519?
7. Marecek J, Macleaod C, Hoggart L. Abortion in legal, social, and healthcare contexts. *Feminism &Psychology* 2017. Vol. 27 (1) 4-14. Available from: http://journals.sagepub.com/doi/pdf/10.1177/0959353516689521.
8. Children by Choice Website. Facts and Figures: Australian abortion law and practice. https://www.childrenbychoice.org.au/factsandfigures/australianabortionlawandpractice.
9. Termination law in New Zealand. BPJ special Edition. Termination of Pregnancy in New Zealand. https://bpac.org.nz/bpj/2010/top/docs/bpjse_top_law_page3.pdf.
10. Baird B. Medical abortion in Australia: a short history. *Reproductive Health Matters* 2015. Vol 23(46):169-176. https://doi.org/10.1016/j.rhm.2015.10.002 .
11. Pocius K, Bartz D, Maurer R, et al. Serum human chorionic gonadotrophin (hCG) trend within the first few days after medical abortion: a prospective study. *Contraception* 2017. 95:263-268.
12. Hulme-Chambers A, Temple-Smith M, Davidson A, et al. *Sexual and Reproductive Healthcare* 2018. Vol 15:23-27.
13. Tomnay J, Coelli L, Davidson A, et al. *Sexual and Reproductive Healthcare* 2018. Vol 16:175-180.

Online access to mifepristone and misoprostol

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An estimated 68,000 women die globally each year from the consequences of unsafe abortion.[1] Complications of unsafe abortion are among the top five causes of direct maternal mortality.[2] In Australia, an estimated 80,000 abortions are performed annually[3] of which 95 per cent are done in the first trimester.[4] There are currently no national data on abortions and differences in legislation across the Australian states and territories complicate this picture. The World Health Organization (WHO) estimates that 92.3 per cent of abortions performed in Australia are done safely, compared to the Oceania regional estimate of 66.3 per cent.[5] There are still reports of women in rural and remote areas attempting unsafe abortion due to a lack of access to services.[4]

Mifepristone, as a safe medical abortion agent, has been licensed for use in Australia since 2012 and was added to the Pharmaceutical Benefits Scheme (PBS) in 2013.[4] When used for early abortion, mifepristone and misoprostol have a success rate of 95 per cent.[6] In 2005, this combination was added to the WHO Model Lists of Essential Medicines.[2] Despite the proven efficacy, safety record and WHO endorsement of this method, there are still access barriers to medical abortion in Australia. These service gaps have started to be addressed through 'telemedicine abortion', the provision of medical termination agents via internet sites and phone services. This article aims to outline the main issues around the unrestricted online availability of abortion medicines.

Medical community issues and concerns

A major concern of the medical profession around unrestricted access to abortion medications has been the lack of pre-abortion care, including accurate dating of the pregnancy, with the potential for women to attempt termination at later gestations, leading to increased complication rates.[8] The evidence suggests the reverse is true, and that online access allows women, particularly in rural and remote areas, to terminate at earlier gestations by removing the necessity to organise family and work obligations to make time to travel.[8] Evidence suggests that using the last menstrual period (LMP) to date an early pregnancy is accurate and acceptable. WHO endorses abortion based on clinical assessment alone without ultrasound dating.[9] However, WHO assumes that in the setting of global healthcare, many women live in areas without access to ultrasound. In Australia, ultrasound can rule out ectopic pregnancy and diagnose non-viability, removing the necessity of abortions for pregnancies that are destined to miscarry.

WHO states that 'safe care includes community level healthcare providers trained in recognition of abortion complications to provide prompt referral for treatment, and transportation to services for management of complications of abortion'.[9] WHO specify that 'healthcare provider' includes 'any properly trained healthcare provider, including mid-level (non-physician) providers'. The provision of care by community nursing posts, with or without medical or midwifery input, might be considered by WHO to be safe. However, variances in training between midwives and nurses working in low-resource environments compared to high-income countries, and expectations of patients accessing care in Australia, need to be taken into consideration.

Post-abortion care is also a consideration, particularly in the event of a complication. The complication rate of early medical abortion is low. Aiken et al reported a success rate of 94.7 per cent (95% CI 93.1% to 96.0%) for women undergoing medical abortion at home via the 'Women on Web' (WoW) internet site.[10] Of 1158 women, seven (0.7%, CI 0.3% to 1.5%) reported having a blood transfusion, and 26 (2.6%, CI 1.7% to 3.8%) required antibiotics. Ninety-three women (9.3%, CI 7.6% to 11.3%) reported experiencing a symptom for which they were advised to seek medical advice and, of these, 87 sought attention. None of the five women who did not seek medical attention reported an adverse outcome. Although this suggests that women are able to manage their own presentation to emergency medical care in the unlikely event of a complication, in Australia, there may be issues around patient access to appropriate emergency services in remote and rural areas.

Another concern regarding home medical abortion is the potential for harm to an ongoing pregnancy in the event of a patient changing her mind midway through the regime, or in the event of treatment failure. Women rarely change their minds after beginning a termination. In the US, less than 0.004 per cent of women taking mifepristone later chose to continue the pregnancy.[11] In such a case, a woman should be counselled that there is a

reasonable chance (10–45%) that the pregnancy will continue normally.[11]

A concern unique to the provision of medicines via online services is the veracity of the product. According to WHO, 'the internet trade in medicines now represents a huge, unregulated (and perhaps unregulatable) market globally, which needs more research and attention'.[12] More than 50 per cent of medicines purchased on the internet from illegal sites that conceal their physical address are counterfeit.[12] The potential impact of this in general terms is enormous, including immediate risks, 'failed' treatment and a loss of confidence in medical services. However, the use of internet sites with a good safety profile and transparent auditing process, such as WoW or Marie Stopes, negates this concern as the medicines are prescribed by licensed medical practitioners.

Patient issues and concerns

Data from WoW has revealed that 49 per cent of women give barriers to access of services (including geographical distance, cost of travel, cost of childcare for existing children and long wait lists) as their reason for accessing online services. Thirty per cent of women have concerns regarding privacy and confidentiality (such as living in a small community and friends or family working in the local healthcare facility), and 18 per cent give fear of threat of partner violence or controlling family as their reason.[13] Similar barriers exist in Australia, particularly in rural and remote settings.[4,14] Access to services, concern regarding shame and stigma and financial barriers, including the costs of travel and accommodation, have been identified as issues in rural Australia.[14] The cost of obtaining a private first trimester abortion ranges from AU$400 to $900,[4] which can rise significantly when the cost of travel and accommodation is taken into account. This compares to the suggested donation of €90 (approximately NZ$155) for New Zealand users of the WoW telemedicine service, where women who are unable to afford this are subsidised by the site's donation policy.[15]

There have been legal ramifications of patients obtaining abortion medicines online for use in Australia. In 2010, a couple were accused of obtaining mifepristone and misoprostol from an overseas source for use in a termination, in Queensland's first ever case of a woman being charged with procuring her own abortion.[3] The drugs were imported for personal use and there was no attempt to smuggle the drugs. Expert evidence was given that mifepristone is a safe medication for the woman, is listed as an essential medicine by WHO and is legally prescribed in Australia. The jury found the couple not guilty, as they were not satisfied that the combination of drugs constituted a noxious substance. The Queensland Criminal Code specifies that it is an offence for a woman to procure her own abortion by self-administering 'any poison or other noxious thing'.[3]

In Australia, transparent pathways already exist for online access to abortion. Marie Stopes offer a telemedicine service to women over 16 years of age in Victoria, New South Wales, Queensland, Western Australia (patients require a GP referral), Northern Territory and Tasmania.[16] Requirements include that the patient lives within two hours of 24-hour emergency medical care, speaks English, has internet access and is no more than eight weeks (56 days) pregnant at the time of the phone consult. The cost of this service starts at $290, excluding the cost of the medications.

Future directions

Access to safe and timely abortion and care are fundamental aspects of women's reproductive rights and healthcare requirements. The introduction of telemedicine has been associated with a decrease in overall abortion rates in other areas.[17] It is likely to be a safe and convenient option for women in areas of Australia and New Zealand with access to suitable emergency care in the rare event of complications. The provision of post-abortion advice, including contraception counselling is an essential adjunct to this service.

Despite the safety profile of first-trimester medical abortion and the growing body of evidence that abortion via telemedicine is used safely by the majority of women, concerns remain. Urgent work is needed at state and federal levels to ensure access to abortion services, resolve legal disparities between Australian states and territories, and to clarify the Australian legal position around abortion via telemedicine. As Petersen[3] puts it, 'There is no regulatory miracle which will stop the traffic of mifepristone and misoprostol, and therefore an intelligent regulatory response is required'.

References

1. Grimes DA, Benson J, Singh S, et al. Unsafe abortion: the preventable pandemic. *Lancet* 2006;368(9550):1908-19.
2. Perehudoff K, Pizzarossa LB, Stekelenburg J. Realising the right to sexual and reproductive health: access to essential medicines for medical abortion as a core obligation. *BMC International Health and Human Rights* 2018;18(8).
3. Petersen K. Abortion laws and medical developments: A medico-legal anomaly in Queensland. *Journal of Law in Medicine* 2011;18:594-600.
4. de Moel-Mandel C, Shelley JM. The legal and non-legal barriers to abortion access in Australia: a review of the evidence. *Eur J Contraception Rep Health Care* 2017;22(2):114-122.
5. Ganatra B, Gerdts C, Rossier C, et al. Global, regional, and subregional classification of abortions by safety, 2010–14: estimates from a Bayesian hierarchical model. *Lancet* 2017; 390: 2372-81.
6. Kulier R, Kapp N, Gülmezoglu AM, et al. Medical methods for first trimester abortion. *Cochrane Database of Systematic Reviews* 2011, Issue 11.
7. Grossman D, Grindlay K. Safety of medical abortion provided through telemedicine compared with in person. *Obstet Gynecol* 2017;130:778-82.
8. Grindlay K, Grossman D. Telemedicine provision of medical abortion in Alaska: through the provider's lens. *Journal of Telemedicine and Telecare* 2017: 23(7):680-685.
9. World Health Organization. Safe abortion: technical and policy guidance for health systems, 2nd edition. 2012 ISBN 978 92 4 154843 4.
10. Aiken AR, Digol I, Trussell J, Gomperts R. Self-reported outcomes and adverse events after medical abortion through online telemedicine: population-based study in the Republic of Ireland and Northern Ireland. *BMJ* 2017;357:j2011.
11. Grossman D, White K, Harris L, Reeves M. Continuing pregnancy after mifepristone and 'reversal' of first-trimester medical abortion: a systematic review. *Contraception* 92(2015) 206-211.
12. World Health Organization. A study on the public health and socioeconomic impact of substandard and falsified medical products. Geneva 2017. Licence: CC BY-NC-SA 3.0 IGO.
13. Aiken ARA, Guthriec KA, et al. Barriers to accessing abortion services and perspectives on using mifepristone and misoprostol at home in Great Britain. *Contraception* 2018;97:177-183.
14. Doran FM, Hornibrook J. Barriers around access to abortion experienced by rural women in New South Wales. *Journal of Rural and Remote Health* 2016; 16:3538.
15. www.womenonweb.org/en/page/9254/donation-system. Accessed 12/04/18.
16. www.mariestopes.org.au/abortion/home-abortion. Accessed 15/3/18.
17. Grossman D, Grindlay K, et al. Changes in service delivery patterns after introduction of telemedicine provision of medical abortion in Iowa. *American Journal of Public Health* 2013;103:73-78.

Mid-trimester surgical abortion

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In 2008, the Abortion Law Reform Act[1] was passed through Victorian Parliament. This effectively removed abortion from the Victorian Crimes Act and legalised it throughout the state. A medical practitioner can be a conscientious objector, but must refer the patient onto a clinician who is able provide appropriate medical assistance.[1] The complex political and social debate that surrounds abortion care, access and service provision will be an ongoing challenge. We need to advocate on behalf of women to provide the best possible abortion care. It is also important that our trainees have access to training opportunities.

The current RANZCOG curriculum mandates training in surgical management of miscarriage and abortion. Most trainees will have exposure to surgical management of first-trimester miscarriage (less than 13 weeks) during their Integrated Training Program (ITP) training. With medical termination (using MS-2Step, a combination of mifepristone and misoprostol) becoming more accepted by women and providers, trainees should obtain adequate exposure to the management issues associated with abortion care in the first trimester.

Opportunities for training often become more limited from the second trimester. Many trainees will not have the scope of practice to be able to confidently perform mid-trimester abortion (after 14 weeks gestation). Coupled with often difficult access to service providers, women may find themselves with limited options if they seek an abortion after 14 weeks gestation. Non-availability of abortion services has been shown to increase maternal morbidity and mortality.[2] Adequate services can only occur if trainees are able to gain the skill set required to support those services, hence the increased need for upskilling in surgical abortion care.

Table 1. Number of cases completed during six-month Advanced Training Module.

Case	Numbers
Complex contraception consults	20
Complex abortion care consults	30
Ultrasound cases	180
Surgical abortion (<14 weeks)	170
Dilation and evacuation (>14 weeks)	40

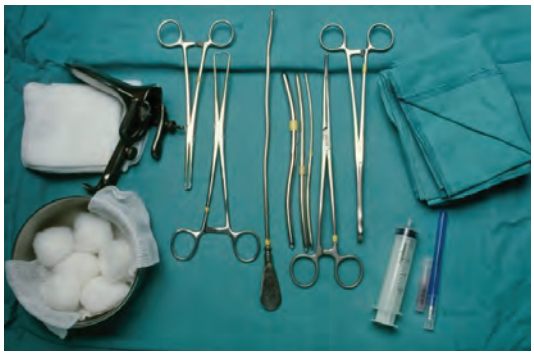
Dilation and evacuation (D&E) is a surgical technique that involves dilation of the cervix and subsequent evacuation of the uterus, by using destructive instruments and a suction catheter. Data are scarce on the number of D&E procedures performed in Australia and access to abortion after 14 weeks is limited, depending on geographical location. The alternative to surgery is a medical abortion, which includes cervical priming with either a laminaria tent and/or mifepristone or misoprostol administration, with a subsequent induction of labour.

Internationally, 10 to 15 per cent of induced abortions occur in the second trimester.[3] Literature suggests that D&E results in fewer adverse events than medical induction for second-trimester abortion.[4] Practice varies widely according to country, for example, D&E is used for 96 per cent of abortions in the second trimester[5] in the US, and 75 per cent in the UK.[6] In Sweden and Finland, contrastingly, nearly all abortions in the second trimester are performed medically.[7]

As an abortion procedure, D&E results in lower reports of pain and fever, and has a shorter hospitalisation time.[4] However, due to the specialised nature of the procedure, providers need to undergo training and maintain an adequate caseload to be safe providers. Due to that limitation, RCOG guidelines recommend that inexperienced providers use medical induction of labour for second-trimester abortion, as it is also effective and well tolerated.[8]

Historically, there have been concerns regarding increased risk of preterm birth with subsequent pregnancies after cervical surgery (for example, cone biopsies or multiple large loop excision of the transformation zone [LLETZ] procedures). Although there have been no randomised controlled trials, the data from recent retrospective studies suggest that there is no increase in rates of preterm birth after surgical D&E.[9,10]

I commenced my training in 2010 at the Mercy Hospital for Women in Melbourne. As a hospital with a Catholic affiliation, we provide abortion care and counselling at the Austin Family Planning Clinic, located on the same campus. This clinic, led by A/Prof Sonia Grover, services the northern suburbs of Melbourne, with an emphasis on the regional and rural communities in the north. The team includes three nurses, four gynaecologists and a senior



Equipment prepared for a surgical abortion procedure.

general practitioner, with a clinic session once a week and a theatre session once a fortnight.

In 2014, the RANZCOG Women's Health Committee highlighted the need for a streamlined training pathway for sexual and reproductive health, to improve access to abortion services. I was fortunate to be part of the pilot for the Contraception Care and Abortion Care components of the Sexual and Reproductive Health Advanced Training Module (ATM), in 2016.

This innovative ATM was provided through the Royal Women's Hospital in Melbourne, under the guidance of Dr Paddy Moore and her team. The aim was to equip trainees with the skill set to confidently provide surgical and medical abortion care in their practice. Available to trainees undertaking the Generalist Stream, the ATM can be completed in combination with general obstetric and gynaecology rotations.

The training components were designed to be completed over a six-month period, with a set number of surgical procedures, ultrasound sessions and counselling sessions undertaken to receive the certification. At the Royal Women's Hospital, the Pregnancy Advisory Service is the state referral base for women requesting abortion care and covers a wide catchment area. Training access included three theatre sessions and four clinic sessions a week.

We have had an excellent response from trainees with an interest in upskilling and providing the surgical expertise to their communities. The work is very rewarding. I have found that about 30 procedures are required for competence in D&E. This may not be easily achievable in a peripheral hospital, but most tertiary referral centres would be able to provide that number of procedural training opportunities. There are plans to expand the ATM to include an online resource to supplement the on-site training and, potentially, roll the module out to interstate sites and New Zealand. Teaching has been a key part of the module and providing upskilling to general practitioners has been a vital part of improving service provision for abortion care.

With the ongoing guidance of the Women's Health Committee, I hope that this ATM will continue to provide Fellows with the skills and knowledge base required to provide abortion care in the second trimester with confidence.

For queries regarding the Contraception Care and Abortion Care components of the Sexual and Reproductive Health ATM, please contact Dr Paddy Moore at paddy.moore@thewomens.org.au.

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References

1. Abortion Law Reform Bill 2008: Explanatory memorandum. Australasian Legal Information Institute.
2. World Health Organization. Unsafe abortion: global and regional estimates of incidence of unsafe abortion and associated mortality in 2000. 2012.
3. Medical methods for termination of pregnancy. Report of a WHO Scientific Group. World Health Organization Technical Report Series. Geneva: World Health Organization, 1997; Vol. 871.
4. Grimes DA, Smith SM, Witham AD. Mifepristone and misoprostol versus dilation and evacuation for midtrimester abortion: a pilot randomised controlled trial. *BJOG* 2004;111:148-53.
5. Strauss LT, Herndon J, Chang J, et al. Abortion surveillance-United States, 2002. *Morbidity and Mortality Weekly Report* 2005;54:1-31.
6. Government Statistical Service. Abortion statistics, England and Wales: 2005. *Statistical Bulletin* 2006/01 July 4, 2006.
7. STAKES. Official statistics of Finland. Induced abortions and sterilisations 2005. Statistical summary 2006.
8. Royal College of Obstetricians and Gynaecologists. The care of women requesting induced abortion. London: RCOG Press, 2004.
9. Kalish RB, Chasen ST, Rosenzweig LB, et al. Impact of mid-trimester dilation and evacuation on subsequent pregnancy outcome. *Am J Obstet Gynecol.* 2002 Oct;187(4):882-5.
10. Kalish RB, Gupta M, et al. Obstetric outcomes after surgical abortion at > or = 20 weeks' gestation. *Am J Obstet Gynecol.* 2005 Sep;193(3 Pt 2):1161-4.

Feticide and late termination of pregnancy

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Late termination of pregnancy, although not rigidly defined, is typically considered as abortion after 20 weeks gestation, and accounts for less than five per cent of all abortions in Australia. It is notable for increased procedural complications compared with first trimester procedures and evokes high levels of conflicting emotions in the community. In Australia, data about late terminations are limited and biased by the distribution of services and legislative variation between the states. This legislative variance leads to limitations around reporting and data availability, with no standardised data collection system, as well as limited provision and access to abortion services. This is especially so for women seeking late termination, with its required expertise and specific ethical and legal considerations.

Indications for late termination

The majority of terminations after 20 weeks gestation in Australia are performed for severe fetal abnormalities or maternal illness, where continuing the pregnancy to viability would potentially compromise the life of the woman. Access to abortion beyond 20 weeks gestation in Australia for other reasons, such as maternal psychological distress or socioeconomic disadvantage, is more restrictive and in some states non-existent. However, the provision of safe late termination services is an imperative of a health system that recommends fetal anomaly screening as a core component of obstetric care. While aneuploidy screening has largely moved to the first trimester, the majority of fetal structural abnormalities remain undiagnosed until the 19 to 20-week fetal anatomy survey in general screening environments. To ensure all appropriate investigations and counselling are completed, parental decision-making is often not possible until well into the second trimester of pregnancy. The RANZCOG guideline on late termination 'recognises special circumstances where late termination of pregnancy may be regarded by the managing clinicians and the patient as the most suitable option in the particular circumstance', referring specifically to twins discordant for anomalies, and conditions where the diagnosis or prognosis is not known until later gestation.[1]

Methods of termination

There are two basic methods for conducting a late termination of pregnancy: a surgical approach (usually dilatation and evacuation with pre-procedural cervical preparation) and a medical approach (induction of labour with prostaglandin preparations, typically with pre-procedural mifepristone). There has been a progressive shift in many countries (the US being a significant exception) from a surgical to a medical approach for pregnancy termination. Both techniques have reasonable safety profiles provided the medical practitioner is adequately trained and skilled in the specific technique employed.

Dilatation and evacuation (D&E) is the predominant surgical technique used for late abortion, although in rare circumstances, hysterotomy or even hysterectomy may be used. With the increasing prevalence of placenta accreta spectrum, hysterectomy may be required when this condition complicates a pregnancy with a severe fetal malformation. Prior to the conduct of a D&E, the cervix requires pre-procedural preparation to reduce the risk of cervical laceration and uterine perforation. Agents used for cervical preparation include pharmacologic agents (such as mifepristone or misoprostol) or osmotic dilators (for example, Laminaria tents [a hydroscopic kelp product] or the synthetic hydrophilic polymer rod, Dilapan). Laminaria typically requires 12–24 hours to achieve maximal cervical dilation compared with 4–6 hours for Dilapan, and the latter is preferred for same-day preparation procedures.[2] Pharmacologic agents, although effective in earlier gestations, do not typically provide enough cervical dilation for later gestation D&E procedures when used alone, compared with osmotic dilators. With advancing gestation, more cervical preparation is required. Many practitioners combine osmotic dilators and mifepristone and/or misoprostol, resulting in greater pre-procedural cervical dilation and shorter procedure times.[3]

Technically, D&E is usually performed under ultrasound guidance with grasping forceps to remove the fetus and placenta, or intact delivery if sufficient cervical dilation can be achieved. There are no robust data to compare the two techniques, although intact D&E requires more time to achieve adequate cervical dilation (usually 1–2 days).

Medical abortion has been significantly affected by the introduction of the anti-progesterone mifepristone, which, when used prior to the administration of prostaglandins (usually the PGE1 analogue misoprostol), reduces the induction to abortion interval by 40–50 per cent compared with the use of prostaglandins alone.[4] Although able to be used at all gestations, the recommended regimens vary with gestation. For late termination (later than 20 weeks gestation), the recommended regimen is 200mg mifepristone orally followed 24–48 hours later by 400µg misoprostol (vaginally or sublingually) every 3–4 hours until fetal expulsion.[5] For late medical termination, a loading misoprostol dose is usually omitted, although this is typically a component of earlier gestation medical termination protocols. Variations in misoprostol dosage regimens are common in late termination, typically based on parity, gestation and prior uterine surgery. Practitioners are encouraged to consider the individual clinical circumstances when prescribing this prostaglandin. Median duration from commencement to expulsion increases as gestation advances, presumably secondary to the greater cervical dilation required to expel the fetus. Virtually all women will have delivered within 24 hours of prostaglandin commencement, with a median duration of 10–12 hours. As with surgical techniques, procedural complications tend to increase with gestation for medical abortion, with the exception of placental retention rates, which decline with advancing gestation.[6] The use of prophylactic third-stage oxytocics to reduce placental retention is recommended.

Feticide

One infrequently discussed aspect of late abortion is feticide, where specific interventions occur to ensure the death of the fetus prior to expulsion. Unintended live birth after abortion can be emotionally difficult for many (although not all) women and poses difficulties for health professionals, both in terms of process and emotion. In a randomised controlled trial of feticide prior to D&E, 91 per cent of participants expressed their preference for fetal death prior to termination.[7] Since 1996, the Royal College of Obstetricians and Gynaecologists has recommended consideration of feticide after 21+6 weeks 'to ensure there is no risk of a live birth'.[8]

In general, feticide is performed by ultrasound specialists who have skills in accessing the fetal circulation to instill intracardiac potassium chloride (KCl) or intrafunic lignocaine, resulting in cessation of fetal cardiac activity prior to the commencement of the termination procedure. In some situations, intra-amniotic or intrafetal digoxin is administered, although this is rarely performed under the auspices of an obstetric ultrasound specialist and has a recognised failure rate. Intracardiac KCl is an effective and safe method to induce prompt fetal cardiac asystole with minimal maternal risk.[9] Little consideration has been provided to the psychological impact on the healthcare team in the provision of a feticide service, even though it is a general recommendation for terminations of pregnancy at gestations later than 22–23 weeks.

Discussion

In summary, feticide and late termination are necessary, but difficult, parts of our profession. They are mostly undertaken in challenging circumstances, with parents confronted by unexpected fetal diagnoses, or those most vulnerable to both the late diagnosis and burdens of pregnancy. This difficulty is compounded by the current legislative variance between Australian states at both practitioner and system levels. For those performing late termination, a clear legal framework is essential and for systems providing antenatal care, a clear pathway to accessing safe, integrated termination services is crucial.[10]

Unfortunately, the burden of this variance is disproportionately shouldered by the most vulnerable in our communities, who may lack the financial and social supports required to access what, in a worst case scenario, may entail a complicated hospital admission in a different state. Fair and equitable access to safe late termination of pregnancy is a reasonable expectation of patients offered routine anomaly screening.

References

1. RANZCOG. Late termination of pregnancy (C-Gyn 17a). Available from: www.ranzcog.edu.au/statements-guidelines.
2. Newmann S, Dalve-Endres A, Drey EA. Society of Family Planning. Clinical Guidelines. Cervical preparation for surgical abortion from 20–24 weeks' gestation. *Contraception* 2008;77:308-314.
3. Goldberg AB, Fortin JA, Drey EA, et al. Cervical preparation before dilation and evacuation using adjunctive misoprostol or mifepristone compared with overnight osmotic dilators alone: a randomized controlled trial. *Obstet Gynecol* 2015;126:599-609.
4. Borgatta L, Kapp N. Society of Family Planning. Clinical Guidelines. Labor induction abortion in the second trimester. *Contraception* 2011;84:4-18.
5. ACOG Practice Bulletin No. 135. Second-trimester abortion. *Obstet Gynecol* 2013;121:1394-1406.
6. Dickinson JE, Doherty DA. Optimization of third-stage management after second-trimester medical pregnancy termination. *Am J Obstet Gynecol*. 2009 Sep;201(3):303.e1-7.
7. Graham RH1, Mason K, Rankin J, Robson SC, The role of feticide in the context of late termination of pregnancy: a qualitative study of health professionals' and parents' views. *Prenatal Diagnosis* 2009 Sep;29(9):875-81.
8. RCOG. The care of women requesting induced abortion. Evidence-based clinical guideline No. 7. November 2011.
9. Pasquini L, Pontello V, Kumar S. Intracardiac injection of potassium chloride as method for feticide: experience from a single UK tertiary centre. *BJOG* 2008;115:528-531.
10. Abortion law in Australia: it's time for national consistency and decriminalisation. de Costa CM, Douglas H. *Med J Aust*. 2015;203(9):349-50.

In reproductive health, is it unconscionable to object?

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Conscientious objection (CO) is a principle that has focused on a diverse range of issues including compulsory military service, assisted euthanasia, access to IVF and abortion. CO is defined as the refusal to provide or participate in legal medical procedures for which a practitioner is normally responsible based on moral or religious grounds. The right to CO in reproductive healthcare is currently legally recognised in some Australian jurisdictions. Additionally, the Australian Medical Association (AMA) upholds that 'as a matter of last resort' a doctor may refuse to provide or participate in legal medical treatments based on 'sincerely-held beliefs and moral concerns'.[1] CO requires a high threshold of personal conviction, although from the patient's point of view, the barriers and harms can have the same effect.

Abortion is available in all Australian states, although there is significant variation between its legal status, barriers to access and geographical availability.[2] Abortion is historically in the realm of criminal law and thus, under the jurisdiction of the States and Territories. Since Federation, they have variously enacted legislation and relied on common law interpretations, effectively creating varying degrees of decriminalisation and an ambiguous legal environment. Of import, not all states permit, from a practical point of view, 'on-demand' termination services.

Professional bodies within Australia and internationally also support access to termination services. RANZCOG recognises unplanned pregnancy as an important health issue and advocates for abortion to be available on the basis of a 'healthcare need'[3] with equitable access across jurisdictions. Likewise, the AMA, the International Federation of Gynaecology and Obstetrics and the World Health Organization have released position statements supporting women's right to access safe and legal termination services.[4,5,6]

However, despite its general acceptance as a lawful procedure, almost all CO in medicine is exercised for abortion. In Australia, the right of doctors to conscientiously object to abortion is only recognised by six jurisdictions and is subject to limitations.[7,8] For example, in Victoria and the Northern Territory, a CO practitioner has a legal duty to declare their status and refer a woman to another practitioner whom they believe does not conscientiously object. Thus, in these jurisdictions all medical practitioners are legally obligated to facilitate abortion. The law places limits on their ability to deny information to women based on their right to CO. Other states, such as New South Wales and Queensland have no specific legislative protections or requirements for CO. Four jurisdictions (Vic, SA, Tas and NT) specifically compel doctors to participate in abortion for the preservation of a pregnant woman's life, regardless of their personal beliefs. In contradistinction, Western Australia is the only jurisdiction that recognises both an individual's right and a hospital's or institution's right to CO.[9]

Professional standards dictated by the AMA[1] and RANZCOG[10] take the approach that while no health professional should be mandated to perform termination of pregnancy, individuals are professionally obliged to provide information and not hinder access to appropriate services.

What is the position of conscientious objectors?

CO in reproductive health came to the fore in the 1960s and 70s with the legalisation of abortion in the UK and US. The acceptance of CO is bolstered by ambiguous criminal laws for abortion, stigma surrounding the procedure and sexist traditional beliefs about women and motherhood. CO is

considered by some to inherently weaken women's reproductive rights and choices in healthcare; since it places more value on a doctor's conscience over a female patient's conscience.

The analogy with military service has been criticised as fallacious. Doctors choose their profession and enjoy positions of power and authority. In particular, they choose to work in women's health when they train as obstetricians and gynaecologists. Whether they work in public or private settings, doctors are remunerated for providing healthcare regardless of any claims to CO or refusal to perform legal treatments. They are not punished for their CO. In fact, it is the woman who is harmed by not being able to exercise her autonomy, not to mention the physical and mental health effects she suffers from delay or inability to access treatment. In conscripted military service, a soldier makes no choice to join and is punished for his/her CO. Conscientious objectors against war do not join active military service voluntarily. The distinction in analogy with military service is important to commentators who criticise CO in reproductive health as a 'dishonourable disobedience' that is unethical and unprofessional.[11]

The acceptance of CO is not universal and indeed some consider it to have no role in modern medical practice. CO has been criticised as the injection of a doctor's values into patient's treatment alternatives and as a form of undesirable paternalism.[12] For example, to obtain informed consent regarding pregnancy care, all valid alternatives including legal termination may need to be discussed in a non-judgmental manner. It seems likely that CO inherently introduces judgment and it is difficult to ascertain the burden or psychological damage which this imparts upon a patient.[13] Savulescu has argued that the role of a doctor, particularly within a public health service, is the delivery of just and legal health services.[12] Permitting moral values (religious or secular) or self-interest will increase inequity and inefficiency in the delivery of health services. Savulescu and Schuklenk[14] assert that the law alone should determine the permissibility of a particular medical treatment and once enacted this requires all qualified health practitioners to provide that treatment in suitable circumstances. If a practitioner objects, their rights should be to protest changes in legislation rather than CO. Indeed, if a practitioner strongly believes that abortion is 'inherently evil', then referral to another practitioner in the knowledge they will perform the 'inherently evil' procedure can hardly be viewed as more morally permissible. Such a practitioner is morally impotent to work under democratically decided laws.

Entry into medical practice is voluntary and individuals should do so with an understanding of the normal scope of medical practice. Indeed, countries such as Finland and Sweden have no legal provision for CO.[14] In the context of the Australian public health system, particularly emergency departments and outpatient clinics, patients cannot normally choose their practitioner. In rural and remote regions, choice of practitioner and health institution will be limited and CO has the potential to limit a patient's right to access lawful healthcare. Despite increasing liberalisation of abortion laws, there has been an international trend towards increasing CO. In the UK, the Conscientious Objection (Medical Activities) Act 2017 is at the committee stage in the House of Lords and purportedly seeks to clarify and broaden the circumstances in which CO is acceptable.[15] Proponents of the bill have raised the case of Greater Glasgow Health Board v Doogan and Another, where two senior midwives, who refused to support and supervise other staff members performing abortions, were ultimately found to have no statutory protection under a claim of CO. The British Medical Association, despite supporting CO in principle, has spoken out against this bill because of fears of patient harm associated with such an extension in a practitioner's right to CO without adequate protection for patients. In the Australian context, studies have already demonstrated evidence of CO being a barrier to care, particularly in regional areas.[16]

Transparency and informed consent

CO provides particular challenges in training and public hospital service delivery by junior doctors. If every trainee is a conscientious objector then a termination service may be shut down. Should CO trainees declare their refusal to provide services to women in their CVs and at interviews? Should trainees who provide comprehensive care for women get paid more for their extra workload and responsibilities?

Female patients deserve fully informed consent when they are receiving medical care. Many women's healthcare practitioners have websites and information pamphlets about their services. Perhaps practitioners should advertise their CO so women are aware of this restrictive aspect of their healthcare provision. Then women can choose their doctor accordingly, before any bill for medical services is paid. Perhaps public hospitals that do not provide termination services should likewise explain the pathways for referral (or lack thereof) for their female patients at the first attendance, allowing women to make informed choices about their pregnancies.

Internationally, high levels of CO in countries such as Italy and Brazil have become a significant barrier to women accessing care. Thus, support for CO only remains a viable option if a community believes in upholding women's reproductive autonomy, when a sufficient number of practitioners are available and willing to provide the service. The validity of an individual's CO is also important and currently Australian practitioners have no legal obligation to register or justify the basis of their objection. In Italy, there have been more than 200 prosecutions of gynaecologists conscientiously objecting in the public system while performing terminations in private practice.[17] Clearly, these cases fail the test 'of sincerely held beliefs or moral values'. In Australia, only some state laws have 'an obligation to refer' and none specify that practitioners should be obliged to register or advertise this objection in advance of the request for termination care being made.

However, the precedence of law over all else, including ethical and moral considerations, gives no heed to the fallibility of law. A valid law is not always moral nor just. Historical examples of valid yet immoral laws can be found in Nazi Germany and the South African apartheid regime. The United Nations Universal Declaration of Human Rights states that everyone has the 'right to freedom of thought, conscience and religion'.[18] Although this right is not considered absolute, to view medical practitioners as merely instruments of the healthcare system might be considered a violation of their human rights. Significant emphasis has been placed by many authors on the importance of health practitioners' right to 'moral integrity'.[19] Academic supporters of conscientious objection to abortion have claimed that, in states such as Victoria and Tasmania with more liberal access to termination

on demand services, medical practitioners may be legally compelled to refer in circumstances where even the most strident supporters of abortion may feel conflicted. Walsh raises the thorny issue of women seeking termination-on-demand for social sex selection.[20] In these states, maternal autonomy is paramount over all other factors and has the emphasis of imposing a state's moral beliefs on all practitioners.

A doctor forced to perform treatments and procedures they believe to be wrong could reasonably be expected to experience feelings of loss of integrity, guilt and even leave the profession as a result.[19] Forced indirect involvement in abortion care does not allow for recognition of the view that abortion is an amoral act or a practitioner's position on 'fetal rights'. However, as argued above, whether or not this is a valid argument for CO remains debatable. CO has a largely religious and non-verifiable basis, placing it in conflict with evidence-based medicine.

In conclusion, there appears to be significant sympathy to CO in reproductive healthcare in Australian law. This is in conflict with the provision of abortion services and maternal autonomy in some geographical areas and public and private hospitals. Should a woman's right to treatment be limited by a health practitioner's CO? The lack of national approach creates a complicated legal and ethical landscape. As a minimum, patients deserve the respect of informed consent and transparency about a practitioner's conscientious objections at the earliest opportunity.

References

1. Australian Medical Association. Conscientious Objection 2013. Available from: https://ama.com.au/position-statement/conscientious-objection-2013.
2. Children by Choice. Australian abortion law. Children By Choice [Accessed 16 January 2018]. Available: www.childrenbychoice.org.au/factsandfigures/australianabortionlawandpractice.
3. RANZCOG. Termination of pregnancy. 2016. Available from: www.ranzcog.edu.au/Statements-Guidelines/.
4. Australian Medical Association. Women's Health Position Statement. 2014. Available from: https://ama.com.au/position-statement/womens-health-2014.
5. International Federation of Gynecology and Obstetrics. Re: World Health Organization (WHO) Guideline on 'Health worker roles in providing safe abortion care and post-abortion contraception'. 2015 Feb. Available from:www.figo.org/figo-statements.
6. World Health Organization. Health worker roles in providing safe abortion care and post-abortion contraception. 2015 July. Available from: www.who.int/reproductivehealth/publications/unsafe_abortion/abortion-task-shifting/en/.
7. de Costa C, Douglas H, Hamblin J, Ramsay P, Shircore M. Abortion law across Australia – A review of nine jurisdictions. *ANZJOG* 2016 Jan; 56(1):118-12.
8. Termination of Pregnancy Law Reform Act, NT, 2017 July. Available from: https://legislation.nt.gov.au/.
9. Acts Amendment (Abortion) Act 1998. WA. 1998. Available from: www.slp.wa.gov.au/legislation/statutes.nsf/actsif.html.
10. RANZCOG. Code of Ethical Practice. 2015. Available from: www.ranzcog.edu.au/about/Governance/Code-of-Ethical-Practice.
11. Fiala C, Joyce A. Dishonourable disobedience. Why refusal to treat in reproductive healthcare is not conscientious objection. *Journal of Psychosomatic Obstetrics & Gynecology* 2014 Dec; 1:12-23.
12. Savulescu J. Conscientious objection in medicine. *BMJ* 2006 Feb; 332: 294-297.
13. Giubilini A. The paradox of conscientious objection and the anemic concept of conscience: Downplaying the role of moral integrity in health care. *Kennedy Institute of Ethics Journal* 2014 June; 24(2): 159-185.
14. Savulescu J, Schuklenk U. Doctors have no right to refuse medical assistance in dying, abortion or contraception. *Bioethics* 2017; 31(3):162-17.
15. Conscientious Objection (Medical Activities) Bill [HL]. House of Lords Hansard; 2018 Jan; 788. Available from: https://hansard.parliament.uk/Lords/2018-01-26/debates/C4A11F08-ABCF-4EA1-AFB5-18174224A982/ConscientiousObjection(MedicalActivities)Bill(HL).
16. de Moel-Mandel C, Shelley J. The legal and non-legal barriers to abortion access in Australia: a review of the evidence. *Eur J Contracept Reprod Health Care* 2017 Jan; 22(2): 114-122.
17. Morrell K, Chavkin W. Conscientious objection to abortion and reproductive healthcare: a review of recent literature and implications for adolescents. *Curr Opin Obstet Gynecol* 2015, 27:333–338.
18. United Nations. Universal Declaration of Human Rights. 1948 Dec. Available from: www.ohchr.org/EN/UDHR/Documents/UDHR_Translations/eng.pdf.
19. Cowley C. A defence of conscientious objection in medicine: A reply to Schuklenk and Savulescu. *Bioethics* 2015; 30(5):358-364.
20. Walsh A. The legal status of prenatal life in Australia. University of Sydney. 2015. Available: https://ses.library.usyd.edu.au/handle/2123/14310.

NATIONAL WOMEN'S HEALTH SUMMIT 2018

THE EVENT & OUTCOMES

MARCH 2018

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Excellence in Women's Health

FOREWORD

Australia is home to almost 13 million women and girls and, in two decades, that number will increase to almost 16 million. Women and men experience wellbeing and illness unequally – disparities in health are present in Australia just as they are found across the world.

Traditionally, the role of RANZCOG has been seen as one of training and standards. However our College has a much broader role – a broader responsibility – to be an advocate for the health of women in general, and for women at disadvantage in particular.

The College is a relatively small not-for-profit organisation, but a powerful one. We have the potential to play a key role as the umbrella group to a broad community-wide coalition advocating for women's health in its broadest sense.

For that reason, I hosted the National Women's Health Summit on Friday, 2nd March in Sydney. The venue, a short walking distance from the place where the First Fleet landed, was selected to emphasise the critical importance of health for the Aboriginal and Torres Strait Islander women who face such incredible disadvantage.

The Summit brought together the 100 Australians with the greatest influence on, and passion for, improving women's health in this country. It was opened by Federal Health Minister Greg Hunt MP, who used the platform to announce a new National Women's Health Policy for 2020–2030, with the Summit as the first step in that process.

However, the day transcended party politics. We heard impassioned speeches from the Shadow Health Spokesperson, Catherine King MP, and Greens Senator Janet Rice. The participants heard from inspiring speakers, and worked towards a national priorities document that has just been released to every person seeking elected office in Australia.

This supplement has been created to capture and share the spirit of the Summit. Women's health cannot be isolated from the social circumstances in which women live. Health is influenced by opportunity, and the Summit showed how we can build partnerships to make life better for half of all Australians.

Prof Steve Robson

RANZCOG President

KEYNOTE SPEAKERS

The Hon Greg Hunt MP

Minister for Health

'It's time to commence the process of a second national women's health strategy. I'd like that to run from 2020 to 2030, and to think of today as the kick-off day in establishing it. [...] Thank you all for your leadership in this space. I thank you and acknowledge you.'

Greg Hunt was elected as the Federal Member for Flinders in 2001, and became Parliamentary Secretary to the Minister for the Environment and Heritage and then Parliamentary Secretary to the Minister for Foreign Affairs. Greg was Shadow Minister in the Environment portfolio between 2007 and 2013, and was Minister for the Environment between September 2013 and July 2016. As Environment Minister,

In January 2017, Greg was appointed Minister for Health. Greg has always had a strong connection with the medical profession and both his mother and wife worked as nurses. Greg will use his background in the Industry, Innovation and Science portfolio to build on Australia's track record for medical breakthroughs, turning what is done in the laboratory into better healthcare for patients.

The Hon Catherine King MP

Shadow Minister for Health

'While the temptation on focusing on women's health tends to be to focus on clinical issues, we must not overlook gender equity issues that affect it. The fact that Australian women pay 10% more for tampons and sanitary products is an issue of gender equity.'

Catherine King was first elected to Federal Parliament in 2001 to represent the electorate of Ballarat. She was re-elected as member at subsequent Federal Elections in 2004, 2007, 2010, 2013 and 2016.

Ms King was appointed Parliamentary Secretary in the portfolios of Health and Ageing and Infrastructure and Transport in the Gillard Government following the 2010 election. As such, she held responsibility in the Health portfolio for nine health regulatory agencies.

On 25 March 2013, Ms King was elevated to the roles of Minister for Regional Services, Local Communities and Territories and Minister for Road Safety. On 18 October 2013, Ms King was appointed to the role of Shadow Minister for Health in the Shadow Cabinet led by the Hon. Bill Shorten. She was reappointed as Shadow Minister for Health and Medicare after the 2016 election.

Brenda Gannon

'Women with lower wages than men in comparable jobs are 2.5 times more likely to have depression than other women and 4.5 times more likely than men'

Brenda Gannon is Professor of Health Economics at the University of Queensland and an international expert in the field of health and ageing economics, and health econometrics, and has won over $21 million, as chief investigator, in collaborative research income with economics, medicine and social science in both academia and industry.

Prof Gannon is currently an Expert Evaluator for the EU Commission funding applications and recently a member of the UK National Institute for Health Research RfPB (Research for Patient Benefit) Advisory Committee. She is a member of the Australian Medical Services Advisory Committee (MSAC) Evaluation Sub Committee.

Patricia Turner

'Australia has a world-class system, but not for all of us. Health outcomes of Aboriginal and Torres Strait Islander women are a long way away from that of the wider population. One solution fits all is not the case... what we are about is putting Aboriginal health in Aboriginal hands.... We are the essence of Australia.'

The daughter of an Arrente man and a Gurdanji woman, as CEO of NACCHO Pat Turner is at the forefront of community efforts to Close the Gap in health outcomes for Aboriginal and Torres Strait Islander people. Pat has more than 40 years' experience in senior leadership positions in government, business and academia, including being the only Aboriginal person, only woman and longest serving CEO of the Aboriginal and Torres Strait Islanders Commission (ATSIC). Among her many appointments, she also spent 18 months as Monash Chair of Australian Studies, Georgetown University, Washington DC, and was inaugural CEO of NITV. Pat holds a Masters Degree in Public Administration from the University of Canberra, where she was awarded the University prize for Development Studies.

Fran Baum

'If you want to improve health you need to improve daily living conditions such as food supply, housing, education and social protection. If we got the conditions of living right, then women wouldn't be turning up in our surgeries.'

Fran Baum is Matthew Flinders Distinguished Professor of Public Health and Foundation Director of the Southgate Institute for Health, Society and Equity at Flinders University, Adelaide, Australia. She was named in the Queen's Birthday 2016 Honours List as an Officer of the Order of Australia for "distinguished service to higher education as an academic and public health researcher, as an advocate for improved access to community health care, and to professional organisations". From 2009–14 she held a prestigious Australia Research Council Federation Fellowship. She is a Fellow of the Academy of the Social Sciences in Australia, the Australian Academy of Health and Medical Sciences and of the Australian Health Promotion Association. She is a member and past Chair of the Global Steering Council of the People's Health Movement – a global network of health activist (www. phmovement.org). She also served as a Commissioner on the World Health Organization's Commission on the Social Determinants of Health from 2005–08.

Senator Janet Rice

'Resources and investments in community networks are small investments with big returns. Strong social connections and networks are so important.'

Janet Rice is a Senator for Victoria and is the Australian Greens spokesperson for Women, as well as LGBTIQ issues, agriculture and rural affairs, transport and forests.

Janet is passionate about supporting women's participation in their communities and in our democracy. The Greens believe that women have the right to equal participation in political, social, intellectual and economic decision-making processes Janet has been a campaigner, consultant, facilitator and activist for more than 30 years. She entered the federal parliament in 2014. She grew up in and still lives in Melbourne's western suburbs with her partner, Penny, and their two adult sons.

Carla Wilshire

'Australia settles 190,000 migrants per year. About 1.7 million people live here temporarily. Our demographics as a country are changing. How does this change health and healthcare needs?'

Carla Wilshire is the CEO of the Migration Council Australia: Australia's national research and policy institution on migration, settlement and social cohesion.

Carla has has worked as a public servant and advisor to Government, principally in the area of migration and resettlement, including as Chief of Staff to the Minister for Multicultural Affairs. Carla is a member of the Judicial Council on Cultural Diversity, which provides policy advice to the Council of Chief Justices of Australia on improving access to justice for culturally and linguistically diverse Australians and she is a Member of the Harmony Alliance Council, Australia's peak advocacy body for migrant and refugee women. Carla is also a member of the National Anti-Racism Partnership and co-founded the Friendly Nation Initiative, which aims to link corporate Australia with the settlement community to improve employment outcomes for refugees.

Anne Trimmer

'Women are over-represented in the unpaid economy. These stats make contributions almost equal between the genders. Supporting women to participate in the workforce is critical to securing their security and independence.'

Anne Trimmer was appointed Secretary General of the AMA in May 2013, commencing her appointment in August that year. Prior to her appointment she served as Chief Executive Officer of the Medical Technology Association of Australia – a position she held following an extensive career in the legal profession, practising law as a commercial partner of a major Australian law firm.

In 2003, Ms Trimmer was awarded a Centenary Medal for services to law and society.

Carmel Tebbutt

Carmel Tebbutt is a former NSW Health Minister and the first woman to hold the position of Deputy Premier in NSW.

Carmel was a Member of the New South Wales Parliament for 17 years, serving in both the Legislative Council and as the Member for Marrickville. Carmel was appointed to the NSW Cabinet in 1998 and held many portfolios including Health, Education, Community Services and the Environment.

Since leaving Parliament in 2015, Carmel was employed as the CEO of Medical Deans Australia and New Zealand and is now CEO of NSW Mental Health Co-ordinating Council.

THE STREAMS

Migrant and Refugee Women

Co-chaired by Dr Talat Uppal and Ms Kate Aubusson

Social exclusion, health service accessibility and literacy, incompatible cultural norms, and mental health issues were discussed. Stream participants stated that healthcare cannot be effectively provided within detention centres and called for a Royal Commission on the issue. They indicated that the psychological and physical damage that retention within these facilities inflicts on migrant and refugee women is appalling and, furthermore, counterproductive for integration.

In addition, participants highlighted the need to consult migrant and refugee women in any policy-making process so that informed decisions are based on this group's specific cultural needs. They stressed the need to provide services that empower refugee and migrant women beyond healthcare; that is, taking into account key social determinants of health. English language literacy, holistic GP care, access to religious and cultural communities, and the availability of interpreters are all necessary for the effective inclusion of migrant and refugee women in the broader Australian community.

Finally, the delegates said that there was a need to provide GPs with culturally appropriate education resources so that lifelong migrant and refugee healthcare is effectively provided. They stressed that fragmented funding needs to be addressed, continuity of services guaranteed, and funding to key grassroots organisations provided for the suggestions to be successfully implemented.

Aboriginal and Torres Strait Islander Women

Co-chaired by Dr Kiarna Brown and Ms Bridget Brennan

Indigenous people are currently the least healthy population group in Australia, with many specific health concerns for women, in particular. Racism and marginalisation still inhibit ease of access to fundamental services, such as healthcare and social welfare. It was also acknowledged that Indigenous people continue to suffer from the trauma of colonisation and the intergenerational impact of the Stolen Generation on their families.

The lack of funding safeguards to secure long-term delivery of health programs within Indigenous communities was high on the list of challenges. Short-term funding is assigned to programs expected to produce long-term solutions. Without secured funding, programs are almost setup to fail.

The focus on workforce upskilling in cultural competency needs to continue. Ensuring the health workforce comprises both Indigenous and non-Indigenous clinicians and healthcare workers that understand and are able to meet the health needs of this population group through an approach underpinned by respect, trust and collaboration was identified as key to addressing barriers of access.

Finally, while racism exists across all industries in Australia, more transparency and accountability measures are needed, particularly within the health sector, as it is well established that racism has a profound effect on health.

Rural and Remote Women

Co-chaired by Dr Louise Sterling and Ms Gina Rushton

Low literacy levels, violence against women and accessibility issues were discussed. Participants highlighted the need to incorporate a nuanced analysis of local reporting on health services, stating that involving local stakeholders when developing or implementing new services, policies or guidelines is essential in order to improve the health of rural and remote women.

Telehealth services cannot be taken as substitute for on-the-ground services. Therefore, a framework for bringing stakeholders together across federal, state and local sectors when addressing particular health issues is necessary. Furthermore, participants highlighted the need to continue training of clinicians in rural settings; stating that promoting rural generalist pathways and expanding this to non-procedural areas of practice (e.g. mental health) would be a good way to address accessibility issues.

Finally, the need to improve health education, impart preventative health campaigns and provide access to social networks was touched upon, given the high rates of teen births seen in rural Australia. Participants stated that compulsory education of contraception in all medical schools and appropriate speciality colleges is paramount and that rebates for provision of long-acting reversible contraception (LARC) should be revisited and legal, financial and geographical barriers to accessing appropriate termination services addressed.

Women with Disability

Co-chaired by Dr Charlotte Elder and Dr Francis Geronimo

Research into the health of people with disabilities in Australia is limited, but available data show that people with disability have poorer mental and physical health than their non-disabled counterparts, in areas not related to their disability. For instance, stigma, bias and discrimination are everyday experiences that people with disability have to contend with in addition to their disability. In 2009, the National People with Disabilities and Carer Council stated: "virtually every Australian with a disability encounters human rights violations at some point in their lives and very many experience it every day of their lives".

Women with disabilities fall into several policy gaps. Firstly, there is a lack of recognition on the contribution people with disability can make to society; and the approach by governments, the health sector and the wider community is often to apply value through the lens of a disability. As a result, policies across all sectors either do not reflect the complexities and agency of the individual, or don't exist at all.

In addition, urgent action should be taken to recognise that people with disability are not a homogenous group. An approach that reflects the complexities that exist within this population group is necessary to addressing barriers of access.

Mental Health and Wellbeing

Co-chaired by Dr Rachael Hickinbotham and Ms Ruby Prosser Scully

For Australian women, mental illness is the leading cause of disability, and a considerable disease burden among non-fatal conditions. Women and girls have higher rates of depression, anxiety and eating disorders, and are more likely to engage in self-harming behaviour than males.

There is evidence to suggest that mental health issues are underdiagnosed in younger women due to the stigma attached to mental health problems. Suicide and suicide ideation rates are also high among both younger and middle-aged women. In 2010, suicide was a leading cause of death among pregnant women and new mothers.

There have been many advances made in the space, including a mental health suicide prevention plan, as well as Medicare-funded domestic violence screening for pregnant women, among other initiatives; however, not enough has changed despite recommendations existing.

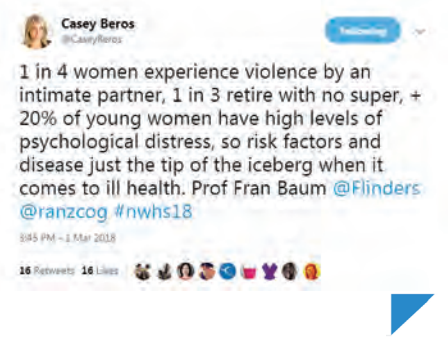
To influence sustainable change, strategies must be implemented at the public policy, community and organisational levels. Programs should reinforce each other and connections between programs identified to strengthen the likelihood of achieving best outcomes while also increasing access.

Healthy Ageing

Co-chaired by A/Prof Janet Vaughan and Dr Sarah McKay

Economic insecurity issues, discrimination and accessibility to health services were discussed. The stream participants highlighted that there has been a 30% increase of hospital admission in people over 85 years of age over the last five years; however, many of the treatments provided in hospitals (e.g. rehabilitation) could be provided in local clinics or even at patients' homes; reducing healthcare overall expenses and making services more accessible. They emphasised a need to shift back to community services and to recognise GPs as the main providers of holistic care.

Women's life expectancy is longer than men's; however, as they age, many women become caregivers; compromising their own health and financial security by giving up employment to care for loved ones and isolating themselves to fulfil carer roles. Shifting healthcare to local community services and instating home visits could ensure these women have a better continuity in their healthcare. Furthermore, the delegates stated the need to create Health-Justice partnerships to address elderly abuse and the need to provide access to community hubs to prevent elderly discrimination and promote social inclusion; highlighting that social capital can provide resilience against poor health through social support and thus, increase overall well-being.



FACEBOOK

(18–24 Feb)		(21–27 Feb)		(25 Feb – 03 Mar)	
49 PAGE LIKES	444%	84 PAGE LIKES	664%	77 PAGE LIKES	57%
8,421 PEOPLE REACHED	262%	13,639 PEOPLE REACHED	451%	14,790 PEOPLE REACHED	76%
1,209 POST ENGAGEMENT	202%	1,407 POST ENGAGEMENT	144%	1,030 POST ENGAGEMENT	-15%
192 PAGE VIEWS	74%	172 PAGE VIEWS	1%	225 PAGE VIEWS	17%

TWITTER

Pre-Summit

611,366 IMPRESSIONS
138 TWEETS
69 PARTICIPANTS

During Summit

Post-Summit

3,882,993 IMPRESSIONS
998 TWEETS
208 PARTICIPANTS

WEBSITE

Acquisition

393 FACEBOOK
113 GOOGLE
62 EMAIL
48 REFERRAL

NWHS Webpage

1,136 PAGEVIEWS
825 SESSIONS
2.55 PAGES PER SESSION
550 NEW USERS
01:16 AVG. TIME ON PAGE

MEDIA COVERAGE

New medical guidelines for pregnancy care

This story has been picked up by 50 news outlets located in six countries and had 16,478 associated social media interactions in the first 47 hours after the original URL was published.

NEWS HITS 50 | POTENTIAL REACH 80.4m | SOCIAL SHARES 16.5k

Weight gain core to new national pregnancy guidelines

This story has been picked up by 16 news outlets located in three countries and had 157 associated social media interactions in the first 46 hours after the original URL was published.

NEWS HITS 16 | POTENTIAL REACH 10.4m | SOCIAL SHARES 157

TWEET HIGHLIGHTS

Congratulations to Royal Aust NZ College Obstetricians and Gynaes on holding the National Women's Health Summit @ranzcog and including the needs of women with intellectual disability in the discussion

Fantastic that @ranzcog led by @DrSteveRobson organized women's health summit with strong focus on #SDH You would have been impressed @MichaelMarmot ideas from #CSDH were very evident

#nwhs18 @janet_rice Secure housing is critical. Affordable #housing is a human right. We know there are women experiencing #homelessness and unstable living environments and this needs to be addressed.

#nwhs18 @GregHuntMP: one in ten women suffer from some form of #endometriosis. We are allocating funding for research, early diagnosis and treatment. #endoMarch

#nwhs18 @NACCHOAustralia Pat Turner: Australia has a world class system, but not for all of us. Health outcomes of Aboriginal and Torres Strait Islander women are a long way away from that of the wider population.

#nwhs18 @CatherineKingMP: Access to affordable, safe and legal termination is critical for governments to address.

Shadow health minister @CatherineKingMP says abortion access is one of the great areas of "unfinished business" in Australian women's health. Murmurs of agreement and a lot of nodding in the room #nwhs18

"The fact that Australian women pay 10% more for tampons and sanitary products is an issue of gender equity." @CatherineKingMP #NWHS18 #TamponTax

#nwhs18 @GregHuntMP Today's the kick-off day of establishing a women's health strategy from 2020-2030. #wmnhealth

#nwhs18 @GregHuntMP: New national pregnancy guidelines have been released today.

#nwhs18 @GregHuntMP: long-term research, women's health initiatives, and attention to endometriosis are key areas of focus for the future.

#nwhs18 @GregHuntMP: The importance and evolution of tele-health is fundamental to get more doctors into rural Australia.

#nwhs18 @GregHuntMP We've gone from a 74 years life expectancy for #women in the 60s to 84 years in 2015. We've got areas of great progress, but still great challenges to face.

ATTENDING ORGANISATIONS

AAIMH (Australian Association for Infant Mental Health)
African Women Australia Inc.
Aged & Community Services Australia
ANU Medical School
Australasian College of Sport and Exercise Physicians
Australasian Menopause Society
Australian Association for Infant Mental Health
Australian Association for Infant Mental Health
Australian College of Midwives
Australian College of Rural and Remote Medicine
Australian Dental Association NSW
Australian Federal Police Association
Australian Government Department of Health
Australian Government Department of Jobs and Small Business
Australian Human Rights Commission
Australian Indigenous Doctors' Association
Australian Medical Association
Australian Medical Students' Association
Australian Psychological Society
Australian Sepsis Network
Australia's National Research Organisation for Women's Safety
Brain Injury Australia
BSPHN/RACGP
Bulgarr Ngaru Medical Aboriginal Corporation
Cancer Council NSW
Cancer Institute NSW
Catholic Health Australia
Cerebral Palsy Alliance
CID (Council for Intellectual Disability)
Commonwealth Department of Health
Community Mental Health Australia
COTA Australia
Disability Advocacy Network Australia
Ernst & Young
Family Planning NSW
Family Planning Victoria
Federation of Ethnic Communities' Councils of Australia
Foundation for Alcohol Research and Education
Gidget Foundation Australia
Gladstone Street Medical Clinic
Health Services Union (HSU)
Hindu Council of Australia
Illawarra Women's Health Centre
Indigenous Allied Health Australia
Intellectual Disability Health Network
Ishar Multicultural Women's Health Centre
James Cook University College of Medicine
La Trobe University
Medibank
Mercy Hospital for Women
Monash University
Multicultural Centre for Women's Health
National Association of Community Legal Centres
National Rural Health Alliance
North Shore Private Hospital
Northern Beaches Health Service
NSW Council for Intellectual Disability
Obstetrics Plus
PANDA
Paul Ramsay Foundation
PricewaterhouseCoopers
RANZCOG
Royal Australasian College of Medical Administrators
Royal Darwin Hospital
Rural Doctors Association of Australia
Safer Care Victoria
Settlement Services International
Sexual Health Quarters (Family Planning Western Australia)
South Australian Health and Medical Research Institute
The George Institute for Global Health
The NSW Education Program on FGM
The Pink Elephants Support Network
True & Children by Choice
University of Melbourne
University of Sydney
University of Sydney
WESNET
Western Sydney University
Westmead Hospital
Women and Newborn Health Service, WA Health

LEARN MORE

Launched on Mother's Day, the National Women's Health Summit Priorities Document captures the discussions held on the day and serves as a call to action to put women's health at the heart of the political agenda.

The Priorities Document can be downloaded from: www.ranzcog.edu.au/nwhs

If you would like to learn more about NWHS outcomes, you can join the mailing list by emailing: media@ranzcog.edu.au

The tyranny of distance for Australian women seeking abortion

Dr Philip Goldstone
MBBS
Medical Director, Marie Stopes Australia

Michelle Thompson
BBus, MBA, GAICD
CEO, Marie Stopes Australia

Charlotte is on track to be the first person in her family to go to university. Smart, driven and very passionate about the field of economics, Charlotte has her eye on a Bachelor of Commerce degree. The day Charotte finds out she is pregnant is the day that the last surgical abortion facility in her home state of Tasmania closes its doors. Ten weeks pregnant, Charlotte can only access a surgical abortion and only if she travels interstate. Charlotte's story illustrates just one of the issues of abortion access in Australia: the tyranny of distance.

Australia is a big country with a highly dispersed population and relatively long distances between capital cities and population centres. While Australians have good access to healthcare compared to many other developed nations, when it comes to abortion, access is not so good.

Abortion is a safe and common health service. Yet it is deeply stigmatised and its availability, legality and cost varies between states and territories. The patchwork access and lack of publicly funded abortion services mean women often need to travel long distances, at great cost, to access a service. The stigma of abortion also means that many women will travel far in order to maintain their privacy.

As a national not-for-profit provider of abortion, Marie Stopes Australia sees the impact that lack of access, social stigma and distance have on Australian women. To get a grasp on the specifics that distance and access plays, we recently reviewed 138,800 medical records from 2012–17, from our clinics across the country. What these records show is not only poignant in terms of the women's stories, but it also reveals how abortion has changed in Australia over the last six years.

Growth of medical abortion

Like most developed nations, the number of abortions being performed in Australia is declining.[2] This is likely due to more effective forms of contraception and better sexual health literacy.[2]

There are two types of abortion accessible in Australia: medical and surgical. Medical abortion, using a combination of mifepristone and misoprostol, became widely available on the Pharmaceutical Benefits Scheme in 2013. Since then, the number of Marie Stopes Australia's patients choosing medical over surgical abortion has grown from 24.7 per cent in 2012 to 39.7 per cent in 2017.

There is no doubt that medical abortion has increased access to the service for Australian women. Most states and territories, apart from the ACT and South Australia, can provide the service in general practice and telehealth settings. However, the service is only available up to 63 days gestation. Beyond that, a surgical abortion is required.

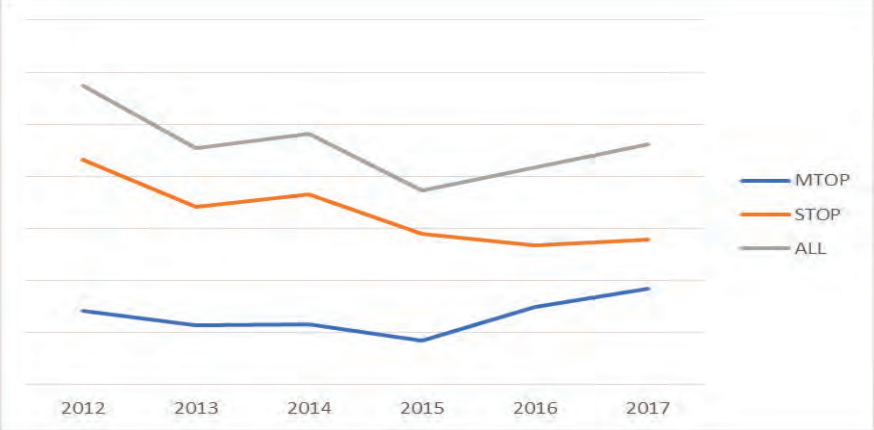


Figure 1. Trend and type of termination of pregnancy (TOP), all States (2012–17).

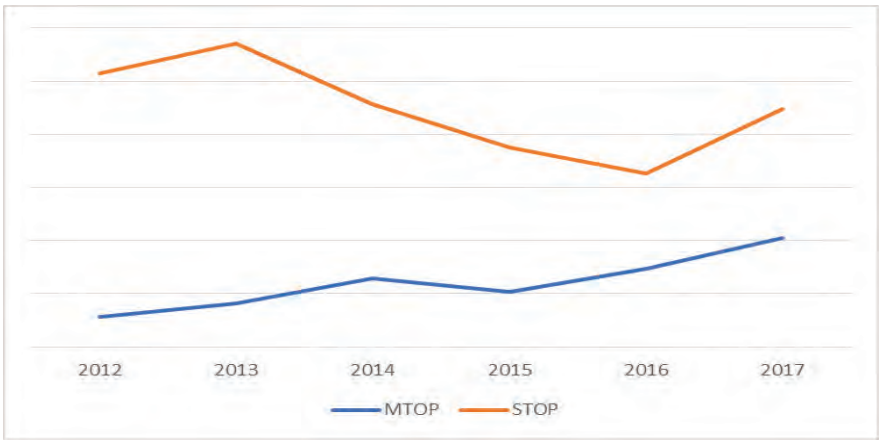


Figure 2. Trend of women who travel to access (TOP) by procedure type.

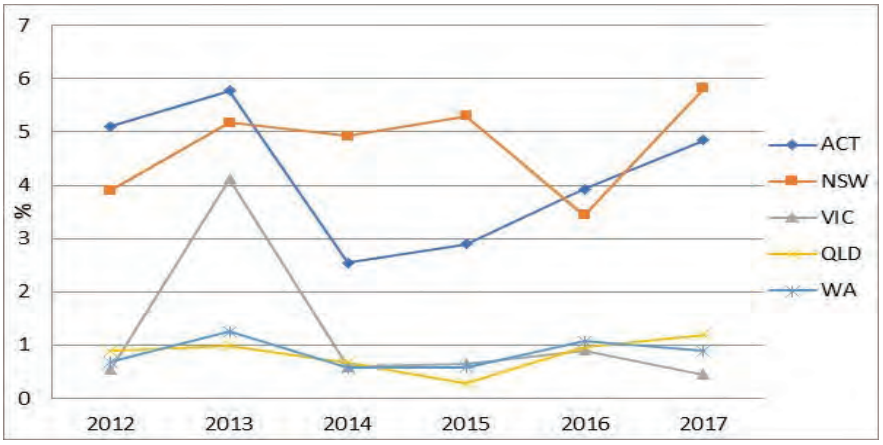


Figure 3. Percentage of women who travelled interstate to access surgical TOP by year (all gestations).

The increase in medical abortion does not spell the end for surgical abortion, as there will always need to be a service available to Australian women based on their gestation, compounding co-morbidities and personal preference. This reinforces the importance of women having access to both medical and surgical abortion procedures in relatively close proximity.

Long distances

Our medical record review has shown that women will travel interstate to access a service. In the past year, the number of women doing so has increased by 22 per cent. While the majority of women are travelling for surgical abortion, women will also travel to access medical abortion.

Of the number of women that travelled interstate to access a surgical abortion, the highest percentage travelled from New South Wales and the ACT. Women from South Australia, where abortion is only available through 'prescribed hospitals', tended to travel to Melbourne, and generally before nine weeks gestation. Women from the Northern Territory travelled to Queensland. Where gestation was over 16 weeks, women from the Northern Territory were more likely to travel to Melbourne or Sydney. Of women in the Northern Territory who travelled, 87 per cent were at least 16 weeks gestation.

Tasmanian women seeking an abortion mostly travelled to Melbourne, with 35 per cent being in excess of 16 weeks gestation. Women from Western Australia were the least likely to travel. Of those who did travel, 59 per cent were in excess of 16 weeks gestation.

It was also rare for Victorian women to travel, with fewer than 100 women accessing clinics in other states over the five-year period. Of those who

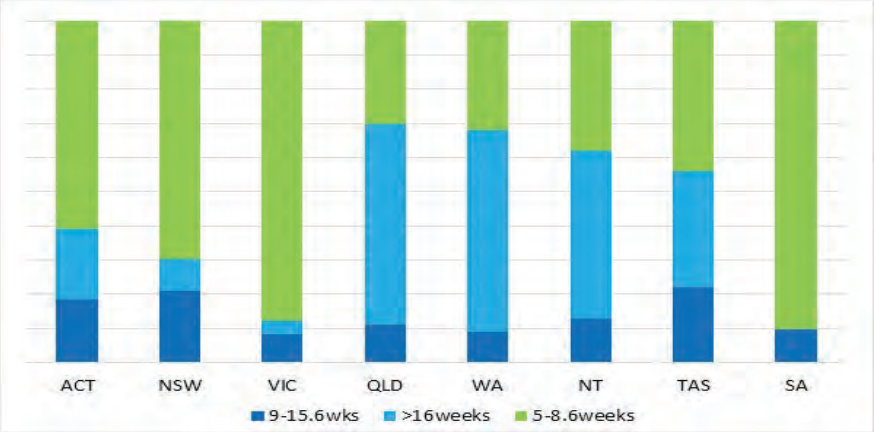


Figure 4. Women who travelled interstate to access a surgical TOP by gestation (2012–17).

did travel interstate, most were from regional or rural Victoria.

Queensland women tended to access services within their own state, a surprising finding given that abortion is still in the Criminal Code in that state. Of those who did travel, 58 per cent were over 16 weeks gestation.

Women prefer early access

Gestation plays a key role in the travel patterns of women accessing abortion. This is understandable given the differing regulation of gestational limits in each jurisdiction. The review of the medical records validates this. It showed that, understandably, women preferred to access abortion early (5–8.6 weeks), and close to where they live. Early access is preferable because it minimises out-of-pocket expenses, negates the need to travel and provides the woman with greater choice (medical versus surgical abortion).

When it comes to later gestation abortion, the majority of women who travelled interstate came from Queensland and Western Australia, followed closely by the Northern Territory and Tasmania. There are a very small number of clinics in Australia that operate beyond 16 weeks gestation, so this trend is understandable. However, it highlights the need for more clinicians and facilities that can provide this service in each state and territory. At the moment, Marie Stopes Australia is the largest provider of abortion services.

What does this tell us?

Many of us working in abortion care acknowledge that the provision of services in the right place and at the right time is challenging. What this analysis has provided is some further guidance on how to assist women in decreasing the need for long-distance travel to access abortion.

Medical abortion has helped increase access for women under nine weeks gestation. However, we can and must do better at increasing the number of registered prescribers. Currently, GPs wanting to provide medical abortion are required to become certified prescribers, by completing a free online training course. O&Gs are not required to complete the course to become certified prescribers.

Providing both surgical and medical abortion services in each state and territory is important. While this is happening to a varying degree, there is, at the time of going to print, no readily accessible surgical provision in Tasmania, limited medical abortion provision in the ACT and limited surgical provision in the Northern Territory.

Patchwork laws and regulations, particularly those governing gestational limits, are not only confusing, they also limit a woman's ability to access abortion services in her state or territory. Having uniform higher gestational limits (for example, up to 24 weeks), could decrease the need for travel. At the same time, we need a larger workforce in abortion care that can provide both services competently and confidently in their home states. This requires consistent national training in abortion care for clinicians.

Addressing stigma around abortion is exceptionally challenging given some of the deeply entrenched beliefs. Australia is, however, a progressive society in a number of ways, so it is important that we tackle the social stigma around abortion. This starts with viewing it for what it is: a common and important health procedure that is necessary for many women in our community.

While this article has dealt with the issue of physical access, the findings of the research tie into the need for greater public provision of abortion care across Australia. Public funding of termination services is patchy and provides uneven access, where some parts of the country have reasonable access, while others have little to no public access. Where a woman lives should not determine her accessibility to a publicly funded service. Ultimately, the fairest way to remedy this is to move state funding of abortion care to the Federal Government and deliver services under the banner of primary healthcare. This will drive reforms at state and territory level and make it less confusing for women. Shifting the funding will also create an opportunity to collect uniform data for epidemiological, policy development and service delivery planning purposes.

References

1. WHO. Safe Abortion: Technical and Policy Guidance for Health Systems (2nd edn). 2012. Available from: http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf [accessed 22 March 2018]. 123p.
2. Guttmacher Institute. Abortion Worldwide 2017. Uneven Progress & Unequal Access. New York: 2018.4.

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists

Excellence in Women's Health

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We need to talk about conscientious objection in our hospitals

Dr Tina Ngorora
MBCHB, FRANZCOG Trainee
Dept of O&G
Waikato Hospital, Hamilton, NZ

There are many questions that arise for healthcare professionals involved with abortion care. Who should perform abortions? How and where should they be performed? What training should clinicians have? Many think the answer to the question, 'Do you perform or assist in abortions?' is simply yes or no; however, the reality is that 'maybe' is also a possible answer. This issue is not black and white, there are many grey areas.

What is conscientious objection (CO)? It is an objection to an action based on moral, religious or philosophical grounds. The issue of CO first became prominent during the World War I, when men refused to fight on religious or political grounds.

What is a conscience? It is an attribute that allows a person to form a sense of right and wrong, and to decide how one should behave when faced with a moral choice. It is a unique faculty that is fundamental to our humanity. Conscience is not infallible and can change.

In New Zealand, the statutes that govern abortion are the Contraception, Sterilisation and Abortion Act 1977, the New Zealand Bill of Rights Act 1990 and the Health Practitioners Competence Assurance Act 2003. This legislation is adapted for healthcare providers in the following documents:

- For the Medical Council of New Zealand (MCNZ): Good Medical Practice
- For the Nursing Council of New Zealand: Code of Conduct
- For the Midwifery Council of New Zealand: Code of Conduct

I feel privileged to work in New Zealand, a country where my right to object to performing abortions is protected by law.[2] Doctors in Sweden, Finland and Iceland who work in public hospitals do not have this protection. In many countries, nurses do not have this protection either.[3,4] The three countries I have worked in each have different laws and, more importantly, different attitudes and interpretation of laws, which leads to markedly different practices. New Zealand employs many medical professionals who have trained and practised in other countries. I have worked in five New Zealand hospitals and, until my current hospital, I had never been asked if I had an objection to performing abortions. I have had to negotiate my own way. This has often been difficult, as some situations have been in conflict with my conscience and my team has not always been prepared for this.

A year ago, I unwittingly joined a discussion on abortion in the tea room. The nurses were discussing a historical event, where a woman undergoing a medical termination began bleeding heavily. The gynaecology registrar conscientiously objected to abortion and declined to attend. The obstetric registrar was unavailable and the nurses felt isolated, unsupported and angry with the registrar. Not realising how traumatic the event had been, I enthusiastically joined the conversation. The staff were surprised to discover that I, too, did not perform abortions. I attempted, without success, to put across the fact that we work in teams and that the hospital is responsible, overall, for women being treated in their facility. I realised there were some very strong views and, sadly, the discussion became personal. I was surprised and disappointed that other viewpoints were not tolerated[5] and that the law and rights of a healthcare provider[2] were misunderstood. I do not know the full details of the event, but it sounded like the doctor involved was also misinformed. This further supports my view that we should be more open about abortion services.

It was after this encounter that I approached the clinical director to start a conversation on CO. I argued that, if we want to give women the best care, we should not leave it to individuals to negotiate their way through a crisis, to only talk about it again after the next crisis. After many emails between the clinical leads, I was asked to prepare a talk for the department. I found some of the responses interesting, further supporting my arguments. One colleague thought some registrars were too young to know their views on abortion. In my talk preparation, I found the District Health Board I worked in had a policy that outlined rights, responsibilities and expectations of both the employer and the employee. There was even a form to sign at the commencement of employment. I discovered that only staff who had worked at my hospital for decades had signed the form when the hospital first starting offering abortion services. The form had somehow fallen by the wayside.

A person who objects to abortion does not need to explain why they object or justify their position. They do, however, need to outline what role they are willing to take, so that the service can be run efficiently and safely. In an emergency, staff who conscientiously object to abortion must assist, because emergency intervention is for the woman's benefit, rather than for the purpose of procuring the termination. Ongoing emergency intervention should not be used to facilitate an abortion where staff involved object.

Women have a right to terminate a pregnancy. However, medical staff have a right not to be involved in the care of women terminating a pregnancy. People object for different reasons, to differing degrees. Upbringing, religious beliefs, laws, the political climate and personal experience all influence a person's decisions. As a house officer, I had a registrar who changed her views when she herself became pregnant for the first time, from having no objection to abortion to only wanting to be involved when there was a serious threat to the woman's life.

Problems arise if two 'camps' are created; those who perform terminations and those who do not, with each passionately defending their position. Unfortunately, the women needing care can fall between the two 'camps'. The disagreement causes an uncomfortable and unsafe work environment. Answers to some questions need to be clarified. What is routine care? What is an emergency? Whose role or responsibility is it? Whose job is it?

I believe there needs to be ongoing organised, open discussion about abortion care. There needs to be education and upskilling of all staff involved. We should encourage mutual respect, compassion and understanding.

In my discussions with the MCNZ and my defence union, they made it clear it is important that women receive the treatment they need and are well looked after. The Medical Council are not concerned about whose role it is within an organisation, as long as it is within the clinician's scope of practice and clinical skills set. In the document Good Medical Practice, the MCNZ does not specify abortion and applies the same standards to CO for any treatment.

I do not perform abortions. I am comfortable discussing treatment options that include abortion, for example, second-trimester rupture of membranes. However, I will refer women to a colleague if abortion is their chosen option.

Discussions around abortion can be difficult, as people have strong views and they do have a right to hold their view. I am challenged when the discussion is aimed at changing my view. I believe it is more constructive and women-centred if the discussion is focused on how to make the termination service work safely, given that I do not perform abortions.

I worked as a Senior House Officer in a Scottish hospital that had a well-run abortion service. In 2004, the termination rate in the Grampian region was around 13 in 1000 women aged 15–44 years.[1] This led to at least five inpatient medical terminations a day at our hospital. The department displayed a list at the nurses' station of medical staff who were willing to be involved in abortion care.

The abortion service was run by two specialist nurses and two gynaecologists. It was clear that those who had an objection were not to be approached for routine abortion care, including prescriptions, other than to treat sexually transmitted infections or for contraception. For prescriptions not in the standing orders, the nurses sought doctors who had no objection first. If a doctor objected to involvement, including in an emergency, the next doctor was sought, including the consultant or even the anaesthetist. We were given comprehensive training on problems in early pregnancy, including first-trimester miscarriages, and skills are transferable to first-trimester abortions. In this hospital, the registrar and consultant were offsite, so when on-call out of hours, I was the only doctor for gynaecology.

If routine medications were not charted and no one willing to do the abortion was available, the treatment was deferred or cancelled. This was a very rare occurrence. I had a very positive experience in this hospital.

We cancel or defer oncology cases if the patient needs ICU and there are no beds, yet we are happy to embark on an abortion procedure without fully equipping staff to handle emergencies and other complex situations, which require an escalation plan.

Statements that I feel are not conducive to an open, progressive discussion about abortion care:

- Why did you choose gynaecology?
- If you care about women, you should have no objection.
- It's about the women, not about you.
- The woman has to wait for someone else when you are right here?
- You are creating more work for your colleagues.
- You are violating women's rights.
- You are violating your oath (the original oath forbade abortion).
- The termination has already started so what difference does it make?
- It was a feticide and the baby is already dead.
- The fetus has severe malformations.
- It is your job.

In the near future, as a consultant, I may be the only doctor available with the skills that could save a dying woman's life. I have opened a dialogue about this with myself.

We need to start talking about abortion care in our hospitals and we need to continue this conversation, because we all care about women.

References

1. Abortion and Repeat Abortion in Grampian. A report for the Sexual Health and Blood Borne Virus Managed Care Network (MCN) NHS Grampian March 2015.
2. Medical Council of New Zealand: Good Medical Practice, Nursing Council of New Zealand: Code of conduct, Midwifery Council of New Zealand: Code of conduct.
3. Dooley D. Conscientious refusal to assist with abortion. *BMJ* 1994 Sep 10.
4. Fiala C, et al. Yes, we can! Successful examples of disallowing 'conscientious objection' in reproductive health care. *Eur J Contracept Reprod Health Care* 2016 Jun.
5. Nordstrand SJ, et al. Medical students' attitudes towards conscientious objection: a survey. *J Med Ethics*. 2014 Sep.

Post-abortion contraception

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Provision of effective reversible contraception following abortion is recognised by the World Health Organization[1] as a key component of integrated care. Given that ovulation can occur as soon as eight days after an abortion[2,3] and more than 50 per cent of women have been reported to resume sexual activity within two weeks after an abortion,[4] early initiation of an effective contraceptive method is essential. Ideally, all women should receive information about, and be offered, effective contraception as part of their care, as delayed provision has been shown to be associated with a higher risk of a repeat unintended pregnancy.[5-9] Available data in Australia indicate that 36.6 per cent of women having an abortion have had a previous termination.[10] Studies from the UK[11-13] report that women value the opportunity to discuss contraception and to be offered their chosen method. In this article, we review the range of contraceptive methods which can be provided after a surgical or medical abortion.

Supporting contraceptive choice

Australian data suggest that more than 50 per cent of women presenting for an abortion were using a contraceptive method at the time of conception, with condoms and the oral contraceptive pill being the most common methods reported.[14,15] An important component of the abortion consultation is a discussion about contraception, including prior contraception use. Information should be provided about the higher relative efficacy of long-acting reversible contraception (LARC), including implants and intrauterine methods, compared to user-dependent, shorter-acting methods such as the contraceptive pill. Permanent sterilisation methods are generally not recommended at the time of termination, as this may be associated with a higher chance of regret.[16]

Contraceptive options after surgical and medical abortion

The medical eligibility criteria from both the World Health Organization[17] and the Faculty of Sexual and Reproductive Healthcare[13] in the UK support the immediate provision of all contraceptive methods after abortion, unless there are medical contraindications for an individual woman. With the exception of intrauterine contraception after a medical termination, contraception can potentially be provided on the same day as a first or second trimester surgical abortion and at the time of prescribing and/or taking mifepristone for a medical abortion.

Hormonal contraception, if initiated within the first five days after a medical or surgical abortion, is immediately effective. Copper-bearing intrauterine devices (Cu-IUDs) are effective immediately when inserted any time after an abortion. Delaying initiation until a later time, including a delay while waiting for a menstrual period to occur, may increase the risk of a rapid repeat unintended pregnancy.

Contraceptive implants

The contraceptive implant can be inserted under the skin of the upper inner arm at the time of a surgical termination. Initiation of these progestogen-releasing devices at the time of mifepristone does not appear to reduce the effectiveness of medical abortion[9] and insertion can occur at the time of prescribing and/or taking mifepristone.

When the implant is inserted within the first five days following a surgical or medical abortion, it will be immediately effective. Alternatively, the implant can be inserted during days one to five of the menstrual cycle with immediate effectiveness, or at any other time using the Quick Start method,[18] even if an undetectable early pregnancy cannot be excluded. In this Quick Start scenario, the woman must understand the need for seven days of abstinence or the consistent use of condoms while waiting for the implant to become effective, as well as the necessity for a follow-up pregnancy test. There is no current evidence to suggest that the bleeding pattern is any different when the implant is inserted at the time of abortion compared to the pattern experienced when it is inserted at other times.

Intrauterine contraception

Intrauterine contraception (IUC) can be inserted at the time of surgical abortion or as soon as expulsion of the products of conception has been confirmed after medical abortion.[19]

Insertion of IUC at the time of abortion is convenient and highly acceptable to women. Clinical guidelines[13,20,21] recommend the immediate insertion of an IUC following surgical abortion at any gestation. There is no increased risk of complications, such as infection or bleeding, for immediate versus delayed insertion of an IUC. There are fewer bleeding problems with immediate insertion of a levonorgestrel-releasing intrauterine system (LNG-IUS) following surgical abortion than following menses. There is some evidence that expulsion may be greater with an IUC inserted following a second-trimester abortion than following a first-trimester abortion. Immediate insertion is associated with higher continuation rates and a reduced risk of repeat unintended pregnancy than when insertion is delayed.[19,22]

Although it is necessary to delay IUC until after confirmation of the expulsion of products of conception, there is no need to routinely wait until the next menses.[23] IUC can be inserted safely at any time after expulsion of the products of conception and the use of ultrasound prior to insertion to exclude an ongoing pregnancy can be helpful. There appears to be no difference in complication rates between insertions conducted within one week of taking mifepristone or two to three weeks later.[13]

However, IUC insertion for a woman diagnosed with infection following abortion follows the same principles as for any pelvic infection and must be delayed until there has been complete resolution of symptoms.

The Cu-IUD is immediately effective from insertion, while the LNG-IUS is only immediately effective if inserted within the first five days after a surgical or medical abortion, or during the first seven days of the menstrual cycle. If the LNG-IUS is inserted at any other time it will take seven days to become effective, during which time condoms or abstinence will be needed.

Injectable DMPA

Depot medroxyprogesterone acetate (DMPA) injections remain a valuable method of contraception for some women and can also be a useful method of bridging contraception following abortion prior to an implant or IUC. An injection can be administered at the time of a surgical abortion and will provide effective contraception for up to 14 weeks. In the context of medical abortion, there is some concern that initiation of DMPA at the time of mifepristone administration may impair the progesterone-blocking action of mifepristone, reducing medical abortion efficacy.[13]

Women having a medical abortion should therefore be advised that there may be a slightly higher risk of continuing pregnancy if DMPA is initiated at the time of mifepristone administration. The risks versus the benefits should be discussed on a case-by-case basis. Women choosing to start DMPA at this time need careful follow-up to exclude an ongoing pregnancy.

Combined hormonal pill

The combined hormonal pill can be initiated on the day of a surgical abortion, although in practice, this usually occurs the next day. For medical abortion, the usual recommendation is to commence the day after misoprostol administration. Provided that pill-taking has commenced within five days of medical or surgical abortion, it will be effective immediately.

Vaginal ring

Although most providers recommend against inserting anything in the vagina during the first week post-abortion, there is little evidence to support this restriction. The vaginal ring can be inserted as early as one day after surgical abortion or misoprostol administration, although waiting two to three days may be preferred for women with heavy bleeding.[24,25]

Progestogen-only pills (POPs)

In Australia, only low-dose levonorgestrel or norethisterone POPs are available, which must be taken within a three-hour time frame each day. This narrow window can make POPs less effective than other methods, although the higher dose desogestrel POP available in New Zealand, which has a 12-hour time frame due to its effect as a reliable anovulant, can be a useful option for women who have contraindications to oestrogen. As with the combined pill, the POP should be commenced immediately, or within five days, after surgical or medical abortion.

Barrier methods

Condoms, either male or female types, can be used immediately after an abortion. Women at risk of STIs can be advised to use condoms at the same time as other more effective methods of contraception. The relatively high failure rate of the diaphragm limits its use for women wanting to prevent pregnancy. It can be used as soon as required after a first-trimester abortion, but should be delayed until six weeks after a second-trimester abortion.[13]

Fertility awareness methods

Although fertility awareness methods can be effective when used diligently and correctly, extreme caution is required shortly after abortion when signs of fertility may be disrupted. Any calendar-based method cannot be relied upon until at least one menstrual period has occurred.[13]

Emergency contraception

There are two types of single-dose emergency contraceptive (EC) pills available without a prescription at pharmacies: the 1.5mg levonorgestrel (LNG-EC) pill or the 30mg ulipristal acetate pill licensed for use up to three or five days respectively after unprotected intercourse. Both act by delaying or preventing ovulation and are most effective when taken as soon as possible. Women should be made aware of EC pill availability and should be offered emergency contraception for any unprotected sex[13] from five days after an abortion. Services could potentially provide women with an advanced supply of an EC pill if clinically appropriate. A Cu-IUD can also be used within five days of unprotected intercourse as a method of emergency contraception, which also provides highly effective ongoing contraception for up to 10 years.

Conclusion

Promotion and provision of effective contraception after abortion is essential to prevent repeat unintended pregnancies and should ideally be integrated within services. The most effective long-acting reversible contraceptive (LARC) methods, namely the implants and IUC, can be provided immediately following abortion. However, if this is not feasible, or if the woman prefers to go back to her GP or a family planning service for contraception, a short-term bridging method should be advised with information provided about the availability of emergency contraception.

References

1. World Health Organization. Safe abortions: technical and policy guidance for health systems: World Health Organization; 2012.
2. Gemzell-Danielsson K, Kallner HK. Post-abortion contraception. *Women's Health* 2015;11(6):779-84. doi: 10.2217/whe.15.72.
3. Schreiber CA, Sober S, Ratcliffe S, Creinin MD. Ovulation resumption after medical abortion with mifepristone and misoprostol. *Contraception* 2011;84(3):230-3. doi: 10.1016/j.contraception.2011.01.013.
4. Boesen HC, Rørbye C, Nørgaard M, Nilas L. Sexual behavior during the first eight weeks after legal termination of pregnancy. *Acta Obstetricia et Gynecologica Scandinavica* 2004;83(12):1189-92. doi: 10.1111/j.0001-6349.2004.00494.x.

5. Rose SB, Lawton BA. Impact of long-acting reversible contraception on return for repeat abortion. *American Journal of Obstetrics & Gynecology* 2012;206(1):37. e1-. e6. doi: 10.1016/j.ajog.2011.06.102.
6. Goodman S, Hendlish SK, Reeves MF, Foster-Rosales A. Impact of immediate postabortal insertion of intrauterine contraception on repeat abortion. *Contraception* 2008;78(2):143-8. doi: 10.1016/j.contraception.2008.03.003.
7. Reeves MF, Smith KJ, Creinin MD. Contraceptive effectiveness of immediate compared with delayed insertion of intrauterine devices after abortion: a decision analysis. *Obstetrics & Gynecology* 2007;109(6):1286-94. doi: 10.1097/01.AOG.0000265336.14160.cc.
8. Raymond EG, Weaver MA, Tan Y-L, Louie KS, Bousiéguez M, Lugo-Hernández EM, et al. Effect of immediate compared with delayed insertion of etonogestrel implants on medical abortion efficacy and repeat pregnancy: a randomized controlled trial. *Obstetrics & Gynecology* 2016;127(2):306-12. doi: 10.1097/AOG.0000000000001274.
9. Hognert H, Kopp Kallner H, Cameron S, Nyrelli C, Jawad I, Heller R, et al. Immediate versus delayed insertion of an etonogestrel releasing implant at medical abortion – a randomized controlled equivalence trial. *Human Reproduction* 2016;31(11):2484 90. doi: 10.1093/humrep/dew238.
10. Scheil W, Jolly K, Scott J, Catcheside B, Sage L, Kennare R. Pregnancy Outcome in South Australia 2015. Adelaide: Pregnancy Outcome Unit, SA Health, Government of South Australia; 2017.
11. Cameron ST, Glasier A, Johnstone A. Shifting abortion care from a hospital to a community sexual and reproductive health care setting. *Journal of Family Planning and Reproductive Health Care* 2016;42(2):127-32. doi: 10.1136/jfprhc-2015-101177.
12. Purcell C, Cameron S, Lawton J, Glasier A, Harden J. Contraceptive care at the time of medical abortion: experiences of women and health professionals in a hospital or community sexual and reproductive health context. *Contraception* 2016;93(2):170-7. doi: 10.1016/j.contraception.2015.09.016.
13. Faculty of Sexual & Reproductive Healthcare, RCOG. FSRH Guideline Contraception After Pregnancy. UK: Faculty of Sexual & Reproductive Healthcare; 2017.
14. Marie Stopes International. Real Choices: Women, Contraception and Unplanned Pregnancy. Marie Stopes International; 2008.
15. Weisberg E, Goldstone P, Heckenberg M, Stewart M. A profile of women terminating pregnancies in NSW. First National Sexual & Reproductive Health Conference; Melbourne: Public Health Association Australia; 2012.
16. Family Planning NSW, Family Planning Victoria, True Relationships and Reproductive Health. Contraception: An Australian clinical practice handbook - 4th edition. Ashfield NSW 2016.
17. World Health Organization. Medical eligibility criteria for contraceptive use - 5th edition: World Health Organization; 2015.
18. Faculty of Sexual & Reproductive Healthcare. FSRH Guideline Quick Starting Contraception. UK: Faculty of Sexual & Reproductive Healthcare; 2017.
19. Gemzell-Danielsson K, Kopp Kallner H, Faúndes A. Contraception following abortion and the treatment of incomplete abortion. *International Journal of Gynecology & Obstetrics* 2014;126:s52-s5. doi: 10.1016/j.ijgo.2014.03.003.
20. RCOG. The care of women requesting induced abortion (Evidence-based Clinical Guideline No. 7): RCOG Press; 2011.
21. Ipas. Clinical Updates in Reproductive Health. Brahmi D, editor. Chapel Hill, NC: Ipas; 2017.
22. Cremer M, Bullard KA, Mosley RM, Weiselberg C, Molaei M, Lerner V, et al. Immediate vs delayed post-abortal copper T 380A IUD insertion in cases over 12 weeks of gestation. *Contraception* 2011;83(6):522-7. doi: 10.1016/j.contraception.2010.10.005.
23. Sääv I, Stephansson O, Gemzell-Danielsson K. Early vs delayed insertion of intrauterine contraception after medical abortion — a randomized controlled trial. PLoS One. 2012;7(11):e48948. doi: 10.1371/journal.pone.0048948.
24. Reproductive Health Access Network. Contraceptive Pearl: Starting the vaginal ring after abortion. 2015. Available from: www.reproductiveaccess.org/resource/contraceptive-pearl-starting-vaginal-ring-TOP/.
25. Fine PM, Tryggestad J, Meyers NJ, Sangi-Haghpeykar H. Safety and acceptability with the use of a contraceptive vaginal ring after surgical or medical abortion. *Contraception* 2007;75(5):367-71. doi: 10.1016/j.contraception.2007.01.009.

Ethically speaking, is a fetus a person?

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Abortion is one of the most divisive moral issues of our time. Since the middle of the 20th century, when surgical abortion became more common in Western countries, there has been intense philosophical debate about its ethics. Abortion demands that we explore some of the most fundamental debates in philosophical ethics, such as whether it is ever acceptable to kill another person; whether the rights of one person (such as a mother) can trump the rights of another (such as a fetus); and whether human life has intrinsic value.

My aim is to provide an overview of just one subset of arguments: the personhood of the fetus. The strengths and weaknesses of two well-known personhood arguments will be considered. My central contention is that both 'pro-life' and 'pro-choice' concepts of personhood of a fetus lead us to conclusions that are difficult to accept. A view that attributes personhood to a fetus implies that all forms of abortion, including embryonic deaths caused by contraceptives, are morally wrong. A view that denies the fetus the rights of a person can be invoked to justify more than abortion. It has, on several occasions, been used as a justification for infanticide.[1] Considering how radical the implications of these two positions are, the majority of people adopt a hybrid account of the personhood of a fetus: an embryo is considered a non-person, whereas a late-term fetus is sufficiently developed to be considered a person.

The central divide

Political debates about abortion revolve around the question, 'Is a human fetus a human being?' Yet, in academic philosophical discussions about abortion, the question of humanity of the fetus is largely uncontroversial. Most academic philosophers argue that the fetus should be considered part of the human species, as it shares our genetic code, and, if unimpeded in it's development, will grow and mature into an adult human being. There are exceptions to this view. Philosopher Michael Sandel argues that a fetus is distinct from an adult human being.[2] However, it is notable that some of the best-known defenders of abortion, such as Peter Singer and Jeff McMahan,[3] concede that a fetus is, at the very least, a human organism. That is to say, a fetus is a member of the species of homo sapiens.

This fact alone, however, does not settle the question of the moral status of the fetus. Singer notes that, 'The biological facts on which the boundary of our species is based do not have moral significance'.[4] Most arguments for abortion stand or fall on a different question, namely, 'Is the fetus a human person?'

Personhood is believed to be the ground of the special moral status that human beings enjoy. 'Persons' have the capacity for acquiring a sense of self and engaging intelligently with the external world. Beings capable of these operations are worthy of special respect (or so the argument goes). If personhood is the ground of moral status, it is, therefore, of crucial importance to determine whether the fetus is a human 'person'. If the fetus is a 'person', then it should be accorded the same rights and privileges as are enjoyed by adult human beings. If it is not a 'person', it need not be.

Two conceptions of personhood are dominant in contemporary philosophical literature. The first is a view that personhood is equivalent to 'rational self-awareness'.[5] Personhood, therefore, refers to the ability of living things to apprehend the world around them: to use language; to have a sense of self; to have preferences and desires; and to have plans for the future. The archetype of this personhood is a fully competent adult human being, who has a rich sense of personal identity, aspirations and goals, and relationships with significant others. According to proponents of this view, a person comes into existence when they develop the proximate capacity for engaging in these sorts of activities (such as when toddlers start to get a handle on conventional language and develop a sense of self).

The alternative view of personhood focuses not on the proximate capacities of a being, but rather on more radical metaphysical capacities that an entity has. From this perspective, a person is a being that has the radical capacity to develop into an adult human being capable of the sorts of activities listed above (the use of language, the development of a sense of identity, and the fostering of relationships with others). What a 'thing' can become is considered more significant than what a 'thing' already is. This concept is referred to as 'potentiality' in metaphysical terms. Proponents of this alternative view of personhood argue that a fetus, though not capable of rational activity yet, nevertheless, has the potential to develop into a being capable of rational activity. It has the capacity to become a being of sophisticated operations, therefore it is a 'person'.

These two views of personhood are ascribed various labels. The first is sometimes called the 'Lockean

view', named after the 17th century philosopher John Locke, who inspired much of the literature on this kind of personhood. The second is the 'Aristotelian view', named after Aristotle, the ancient Greek philosopher responsible for the notion of metaphysical potentiality.

These two views of personhood, one counts the fetus as a person and one does not, lead us to different conclusions about the moral status of the fetus. In one view, the fetus is a person and has the same special moral status as an adult human being. In the alternative view, a fetus is not a person and, while it may have some sort of moral status, does not have the same rights and privileges as a fully developed human being.

In the Lockean view, abortion does not involve the termination of the life of a person. All other things being equal, abortion is therefore morally permissible. In the Aristotelian view, abortion is morally as serious as terminating the life of an adult human being, as both an adult and a fetus are people.

Objections and nuances

Both positions have been subject to strong and sustained criticism since they were first expounded. The Aristotelian view is seen by many as being overly dependent on vague metaphysical terminology. Ideas such as 'potentiality' are difficult to accept for people living in a post-Enlightenment age that is generally suspicious of essentialist conceptions of human nature. It is also difficult to accept its implications in the context of embryonic deaths caused by contraceptives. The Aristotelian view leads us to see abortifacient contraceptives as being just as morally reprehensible as a third-trimester abortion. This would be an unacceptable conclusion for most people in societies where contraception is widely used and generally seen as being morally unproblematic. The Aristotelian view also leads us to regard spontaneous abortion as being just as tragic as the death of a post-birth human being. Yet sociologically, we do not mourn the death of a fetus in the same way we mourn the death of an infant or toddler. The Aristotelian view is counter-intuitive in this respect.[6]

The Lockean view, however, invites what may be even stronger objections. It supposes that only those individuals who have preferences, a sense of identity and a grasp on language have special moral status. This has radical conclusions for the way we treat infants, intellectually disabled people and the demented elderly. Where someone has either not yet developed or lost the capacity for rational and free activity, can we treat them as we treat other animals? This sort of question is often dismissed as a form of scaremongering. Yet, Italian philosophers Alberto Giubilini and Francesca Minerva answer it in the affirmative, and have argued in favour of post-birth infanticide up to two years of age.[7] The Lockean view, in this sense, seems to be ageist and ableist in the extreme. It is not only philosophically implausible, it is close to horrifying.

Conclusion

This discussion is a far cry from the empirical commentaries typically published in *O&G Magazine*. Yet, it is crucially important to step back from the neutral language of empirical analysis and consider the ethical issues attendant to practices in obstetrics and gynaecology. Ethics performs the important task of making us less complacent in our moral views. Many readers may be in favour of abortion up to some point. Yet, honest ethical reflection on the issues will hopefully lead us to acknowledge the difficulties involved in defending a 'pro-life' or 'pro-choice' position on abortion. Awareness of this will hopefully lead people to refrain from glib, rhetorical dismissals of viewpoints that conflict with their own.

Ultimately, most people adopt a hybrid account of personhood, according to which an embryo is a non-person, while a late-term fetus is a person. Embryos have no capacity for sentience (yet alone consciousness), whereas a late-term fetus has basic capacities for processing stimuli from the external world. The main question for defenders of this hybrid position is whether these biological differences can be translated into a morally defensible position on early abortion. Singer and McMahan are suspicious of arguments that use biological facts to justify moral positions on abortion.

References

1. See, for example, Michael Tooley. Abortion and Infanticide. Philosophy and Public Affairs. 1972 2(1):37-65; Alberto Giubilini and Francesca Minerva. After-birth Abortion: Why Should the Baby Live? *Journal of Medical Ethics* 2013 39:261-263.
2. Michael Sandel. Embryo Ethics. The Moral Logic of Stem Cell Research. *New England Journal of Medicine* 2004 351(3): 207-209.
3. Peter Singer. Practical Ethics 3rd ed. London: Cambridge University Press, 2011; Jeff McMahan. Killing embryos for stem cell research. *Metaphilosophy* 2007 38:170-89.
4. Singer 2011, 75.
5. Cf. Singer 2011, 74-75.
6. For a response to this criticism, see John Finnis, 'Abortion and healthcare ethics', in Peter Singer and Helga Kuhse (eds), Bioethics: an anthology hoboken: Wiley 2016. 15-22;17.
7. Giubilini and Minerva 2013.

Psychological effects of abortion

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A few years ago, I started offering abortion in my obstetric and gynaecology practice. As the service gradually became more well-known, I met women in many different circumstances. I have found my perceptions regarding abortion have changed, as these women have told me of their experiences. Perhaps the most salient insight is that there is no single psychological response to abortion. It is not only that an unwanted pregnancy is an emotionally charged situation. As doctors, we are educated on how to communicate with people in difficult circumstances. Concepts such as 'breaking bad news' and the five stages of grief are part of our training and serve us well. In obstetrics and gynaecology, we understand that miscarriage or stillbirth is, for most women, an unalloyed sadness, and this guides us in how to respond. Unplanned pregnancy and the decision to terminate is complex. Doubt, guilt, grief and regret can be tempered by relief, empowerment and determination.

Research on psychological effects

Inherent difficulties with researching the psychological effects of abortion include defining appropriate comparison groups and the extremely emotive nature of the research topic. A meta-analysis of 22 studies with more than 800,000 participants concluded that there was an 80 per cent increased risk in mental health problems, with 10 per cent of this risk attributable to the termination.[1] The strongest psychological effects were observed when women who had an abortion were compared with women who had carried a pregnancy (not necessarily unwanted) to term, and when the outcomes measured related to substance use and suicidal behaviour. The effects were reported lower in comparison groups who had wanted, but not received an abortion, and in women who had not been pregnant at all. At the time of publication, there was considerable debate regarding the nature of this meta-analysis, study selection and choice of comparison groups, reflecting the controversial nature of this research.

Conversely, it has been suggested that abortion may have some mental health benefits compared to continuing with an unwanted pregnancy. A 2013 meta-analysis of eight studies found there was no evidence that abortion reduced the risk of mental health disorders, but was associated with small to moderate increases in anxiety, substance abuse and suicide.[2]

Once women realise they are unexpectedly pregnant, appropriate comparison groups for studies of abortion may be women who choose to continue with unplanned pregnancy, or women who are unable to access abortion. The Turnaway Study reported on 956 women approaching clinics in the US for an elective first-trimester abortion, with no known fetal anomalies or fatal demise, and no maternal health indications for termination.[3] Women were split into three groups: women up to two weeks before the gestational limit who had an abortion (near limit group); those up to three weeks beyond the gestational limit who did not have an abortion (Turnaway group); and those who received an abortion in the first trimester. Two-thirds of women in the Turnaway group eventually had a live birth, while one-third either miscarried or terminated the pregnancy elsewhere. The study was conducted across 31 clinics with gestational limits from 10 weeks until the end of the second trimester. There was, therefore, some overlap of gestation across the three groups.

Women enrolled in the Turnaway Study were initially interviewed eight days after receiving or being denied an abortion and then every six months for five years. Study outcomes included six measures of mental health and well-being: two measures of depression, two measures of anxiety, as well as self-esteem, and life satisfaction. The results showed that women who were unable to have an abortion, in particular, those who later miscarried or had an abortion elsewhere, had the most elevated levels of anxiety, and lowest self-esteem and life satisfaction one week after being denied a termination, which quickly improved to levels similar to those in the other groups by 6–12 months. In general, the authors concluded that, while there were some negative psychological consequences of being unable to access an abortion, these differences converged after 6–12 months and there was no difference after five years. The women who had to proceed with unplanned pregnancy after initially seeking an abortion did not differ from other groups. There was no group of women who decided to proceed with an unplanned pregnancy.

A large Danish record linkage study compared risk of psychiatric contact in the nine months before and after first-time abortion, with the risk before and after a desired first childbirth. Using data from 84,000 abortions and 280,000 births, they found there was no increase in psychiatric treatment associated with first-trimester abortion, while there was a significant increase in treatment associated with birth of a first child.[4] The wide range of results highlights the difficulties in researching the psychological effects of abortion. It seems reasonable to conclude that there are negative psychological consequences of unplanned pregnancy and abortion, but that

these may subside over time. It does not seem that abortion is psychologically protective, but childbirth itself is also associated with significant psychological risk for some women. Given that women terminating a pregnancy may have a wide range of psychological stressors prior to and after their unplanned pregnancy, it is important that every case be considered individually.

Practical considerations

If the best approach is not necessarily 'breaking bad news' or explaining the five stages of grief, how should we support these women in often brief clinical settings? It is not appropriate to impose our own beliefs on our patients' choices and, for example, Tasmanian law provides that practitioners who have a conscientious objection to abortion must provide women seeking termination with a list of prescribed health services from which they can seek advice, information or counselling on the full range of pregnancy options.[5] To conclude with a personal observation, prior to medical school, I trained as a psychologist, and if there was one idea that I would take from the training, it is Carl Roger's concept of unconditional positive regard.[6] In this component of humanistic therapy, the central tenet is of acceptance and support of the patient, regardless of the decisions they make. We can facilitate this by supporting their choices and identifying other supports they can access. Abortion is, for many women, associated with short and long-term psychological distress. While this is not invariably the case, providers should be alert to this possibility and provide assistance where they can.

References

1. Coleman PK. Abortion and mental health: quantitative synthesis and analysis of research published 1995–2009. *The British Journal of Psychiatry* 2011. 199, 180-186. doi: 10.1192/bjp.bp.110.077230.
2. Fergusson DM, Horwood LJ, Boden JM. Does abortion reduce the mental health risks of unwanted or unintended pregnancy? A re-appraisal of the evidence. *Australian and New Zealand Journal of Psychiatry* 2013 Sep;47(9):819-27. doi: 10.1177/0004867413484597.
3. Biggs MA, Upadhyay UD, McCulloch CE. Women's mental health and well-being 5 years after receiving or being denied an abortion: a prospective, longitudinal cohort study. *JAMA Psychiatry* 2017;74(2):169-178. doi:10.1001/jamapsychiatry.2016.3478.
4. Munk-Olsen T, Laursen TM, Pedersen CB, Lidegaard O, Mortensen PB. Induced first-trimester abortion and risk of mental disorder. *New England Journal of Medicine* 2011; 364:332-339 DOI: 10.1056/NEJMoa0905882.
5. Tasmanian Government. Reproductive Health (Access to Terminations) Act 2013. Accessed 17 April 2018.
6. Wikipedia contributors, 'Unconditional positive regard', Wikipedia, The Free Encyclopedia: https://en.wikipedia.org/w/index.php?title=Unconditional_positive_regard&oldid=831542069 (accessed April 22, 2018).

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‘For the sake of the woman’s life and health’

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Throughout history women have sought to control their fertility and abortion has always been a part of this. Written fragments surviving from ancient Egyptian, Greek and Roman times contain many details and prescriptions of plants and herbs that could act as contraceptives or abortifacients. Some of these, such as pennyroyal, continued to be used for hundreds of years until the early 20th century, presumably because, although there may have been serious side effects, they were often successful in bringing about a termination.

Two truths about abortion emerge from this history: women with unintended unwanted pregnancy will seek termination regardless of whether it is legal or acceptable in the society in which they live; and women who cannot obtain safe, legal termination will seek, and often find, unsafe illegal abortion.

The ‘modern’ history of abortion, insofar as it affects Australian women today, began in the middle of the 19th century, in the UK. In 1861, UK Parliament passed the Offences Against the Person Act. Section 58 of this Act decreed that any person ‘who unlawfully uses an instrument to procure the miscarriage of a woman, whether she is with child or not, is guilty of a felony punishable with penal servitude for life.’ There was an exception to the 1861 Act in ‘therapeutic abortion’– justified if the woman’s life was in danger – but the definition of ‘therapeutic’ was unclear and there were virtually no abortions openly performed by registered medical practitioners.

The point of the legislation was partly to protect women from unsafe and unskilled attempts at instrumental abortion, but also to punish them for their ‘immorality’. The Church took an increasingly authoritarian stance on abortion from the 19th century onward, with the strong message that a woman who had demonstrably taken part in sexual intercourse should pay the price by continuing the pregnancy. The legislation failed to achieve the first of these. Women in the UK sought out abortion wherever they could, from providers with few or no skills, and little knowledge of antisepsis. It did, however, provide significant punishment to women. Being clandestine, abortion was a major cause of maternal mortality in the 19th and the first half of the 20th century, and many women who survived did so with chronic ill health.

From 1861 onwards, the harsh measures of the Act meant that prosecutions for abortion providers were relatively common in England. However, in virtually all cases, the defendants were women with little or no medical training, performing terminations for small fees – the so-called ‘backstreet abortionists’. At any one time, around 50 women convicted of the crime of abortion were incarcerated for up to 14 years in London’s Holloway Prison. Their motivation was not necessarily purely financial. One woman said, ‘I knew it was against the law, but I didn’t think it was wrong. Women have to help each other.’

Increasingly, in the early years of the 20th century in the UK, there were calls for reform of law by women (and some men) who were involved in achieving the vote for women and in seeking better reproductive and maternity care. These demands were supported by a small numbers of doctors, including Mr Aleck Bourne, FRCS, consultant gynaecologist at St Mary’s Hospital in London.

In July 1938, Bourne stood in the dock of the Old Bailey court in London, charged under Section 58 of the 1861 Act.[1] Bourne was definitely not a ‘backstreet abortionist’, although he shared the altruism of some of those women: he had charged no fee for performing the allegedly criminal procedure. There was the exception to the 1861 Act in ‘therapeutic abortion’ but the definition of ‘therapeutic’ was unclear. Bourne was determined to test the law in court with the intention of defining ‘therapeutic’ abortion and he was prepared to risk conviction to do so.

The person at the centre of the case was a 14-year-old girl. She had been gang-raped in London’s Whitehall by three Horse Guards, who in June 1938 were convicted and jailed. England’s Attorney-General personally led the prosecution of Bourne. In his opening remarks to the court, he made it clear that he was well-disposed toward the girl. He explained that her parents had taken her to see Dr Joan Malleson, a London general practitioner. Joan Malleson was a woman of liberal views and strong personality. She was an active member of the Birth Control Movement and largely responsible for establishing the original English Family Planning Association. It was Dr Malleson’s opinion, and that of the police surgeon who had seen her following the rape, that ‘curettage’ – surgical abortion – should be allowed to her.

Dr Malleson wrote to Bourne asking if he would be prepared ‘to risk a cause célèbre and undertake the operation.’ Many people, she said, held the view that the best way of correcting the laws in England was to let the medical profession extend the ground for ‘therapeutic abortion’ in suitable cases until the law

had become obsolete as far as practice went. She believed that public opinion would be very much in favour of the abortion conceived in a case such as this.

In 1935, Bourne had been referred a similar case, a girl of 15, and after consultation with a colleague he had terminated that pregnancy. He had been criticised by other colleagues and his registrar had left the operating theatre midway through the surgery. This 'annoyed me,' he wrote with true British phlegm. 'I decided that should another similar opportunity come my way I would report what I had done to the police.' He therefore replied immediately to Joan Malleson's letter: 'I have done this before and have not the slightest hesitation in doing it again.' In early June, the girl was admitted under Bourne's care to St Mary's and, on 14 June, he operated 'with no difficulty and afterwards there were no complications of any kind.'

Bourne was finishing his operating list that evening when he learned that police officers from Scotland Yard were waiting to see him. Chief Inspector Bridger told Bourne that 'in no circumstances could he countenance the operation on humanitarian grounds.' Bourne replied crisply that it was not the Inspector's right to dictate to him what he should or should not do in the best interests of his patients, adding that most medicine was performed on 'humanitarian grounds'. Since he had already operated on the girl, Bourne said, perhaps the Chief Inspector should arrest him. So in due course, Bourne appeared in the local Magistrates' Court, where after formal evidence was given he was committed for trial and released on bail of £200.

Aleck Bourne (centre) with colleagues from the Council of the British College of Obstetricians and Gynaecologists, taken in College House, Queen Anne Street, London, in 1934. Image on loan from the RCOG Archives.

The Attorney-General prosecuting called no medical witnesses to the trial, while Bourne's team called senior psychiatrists and gynaecologists to support his defence. The police surgeon told the court his examination showed the result of 'violence and rape'. The prosecution did not dispute these facts, but based their case on the argument that the abortion had not been needed to preserve the life of the girl. There was no certainty of her death if her pregnancy had continued.

Bourne and his team argued strongly that life did not merely mean the risk of the girl's death, but encompassed her future physical and mental health. His eminent medical witnesses agreed unanimously that 'severe mental or nervous breakdown seemed likely to occur if the girl's pregnancy was not terminated' and described other similar cases that had been followed by such consequences. Bourne himself stated that he could not draw a line between danger to life and danger to health. 'If one waited for danger to life, the woman would be past assistance,' he pointed out. He emphatically included mental with physical health in overall 'health' – each kind of health was essential for the other, he said.

Mr Justice Macnaghten then addressed the jury, and it is on this address that doctors charged with procuring abortion elsewhere in English-speaking jurisdictions in following years based their (successful) defences. The judge spoke of the difficulties in individual cases of making the sharp distinction between life and health. He concluded: 'If the doctor is of the opinion, on reasonable grounds and on adequate knowledge, that the probable consequences of the continuation of the pregnancy would make the woman a physical or mental wreck, then he operates, in that honest belief, for the purpose of preserving the life of the mother.' The jury took 40 minutes to deliberate on Macnaghten's remarks and returned a verdict of 'not guilty'.

I have dwelt at length on Bourne's case, as the outcome played a significant role in the various cases that from 1969 onwards were brought against Australian doctors, in which these practitioners were charged under Australian state criminal laws worded exactly as the 1861 UK Act (which, interestingly, was superseded in 1967 when the Liberal MP David Steel successfully brought the current Abortion Act to Parliament, legalising abortion and making it widely and safely available in most of the UK). These cases, in all of which the accused doctors were acquitted, acted as the defence for doctors providing abortion in New South Wales, Queensland, Victoria, Tasmania and Western Australia until the end of the 20th century, and continue to do so in New South Wales and Queensland, the other three states having reformed or decriminalised their laws.

Until the late 1960s, women in Australia, as in the UK, mostly accessed 'backstreet abortionists', often ending up in public hospitals with sepsis or haemorrhage, a situation vividly described by the prominent pro-choice activist Dr Jo Wainer in her book 'Lost'.[2] There were doctors in most capital cities

who, for substantial fees, would provide surgical terminations, but these too, being clandestine procedures, often resulted in complications.

In Melbourne, in 1969, Dr Ken Davidson was prosecuted by police for allegedly performing an abortion and the case was heard by Justice Cliff Menhennitt. Bourne's case was crucial to Menhennitt's reasoning about the Davidson case in his address to the jury. Menhennitt ruled that a defence to termination exists if the doctor 'honestly believes' on reasonable grounds that the termination is necessary to preserve the woman from serious danger to her life or her physical or mental health. The doctor must also honestly believe that, in the circumstances, the risks of the abortion are in proportion to those of continuing the pregnancy (that is, the termination itself does not seriously threaten the mother's life). Menhennitt's favourable directions to the jury led to Dr Davidson's acquittal. The Menhennitt ruling became the basis on which abortion was safely and openly offered to women in Victoria from 1969 onwards. The first clinic to openly offer abortion in Melbourne, the Fertility Control Clinic, was founded by Dr Bert Wainer in 1972.

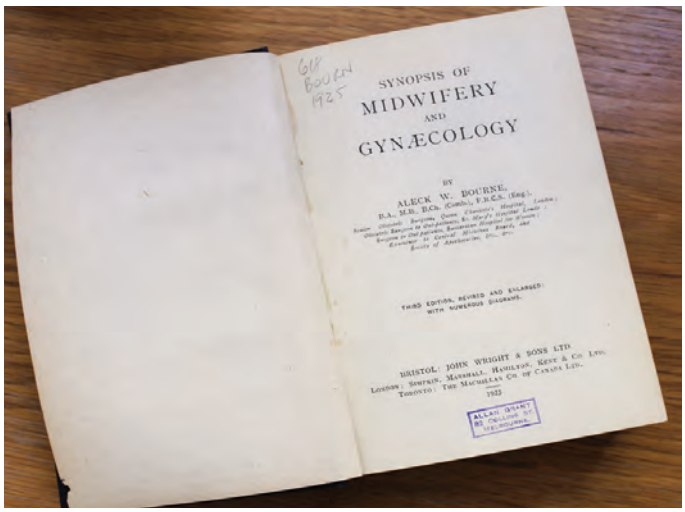
In New South Wales, abortion was, in 1969, and is still, in the NSW Crimes Act 1900 (sections 82, 83 and 84) with penalties of up to 10 years imprisonment for the woman, the doctor and anyone who assists. While the Act does specify that abortion is a crime only if it is performed 'unlawfully', it does not actually define when abortion would be considered lawful or unlawful.

To help clarify the situation, Judge Levine, in 1971, established a legal precedent similar to Menhennitt's. In a case against Dr Wald, in which the doctor was acquitted, Levine allowed that an abortion should be considered lawful if the doctor honestly believes on reasonable grounds that 'the operation was necessary to preserve the woman involved from serious danger to her life or physical or mental health which the continuance of the pregnancy would entail' and that, in regard to mental health, the doctor may take into account 'the effects of economic or social stress that may be pertaining to the time'. Levine also specified that two doctors' opinions are not necessary and that the termination does not have to be performed in a public hospital, opening the way for the appearance of easily accessible and safe clinics in NSW, among the first of which was the Preterm Clinic in central Sydney. Levine's judgment was followed by the judgement of Justice Michael Kirby, in 1994, that further liberalised the grounds for the performance of abortion in NSW; nevertheless, abortion remains in the criminal legislation.

Similarly, in 1985, Dr Peter Bayliss was charged under Section 224 of the Queensland Criminal Code with performing an abortion at his Greenslopes Clinic in Brisbane. The case was heard in front of a jury, by Justice McGuire. Addressing this jury McGuire stated: 'In my opinion, Bourne and those cases to which I have referred (Davidson and Wald), which have their genesis in Bourne, substantially represent the law of Queensland. I am of the opinion that Davidson... represents the present law of Queensland, and I interpret Section 224...of the Queensland Criminal Code accordingly.' In other words, McGuire advised the jury, they must decide if the accused held an honest belief that the abortion was necessary for the preservation of the woman's physical and/or mental health, and that the risks of the termination itself were relatively small. The jury returned a unanimous verdict of not guilty. This judicial ruling still forms the basis of a defence upon which any 21st century Queensland doctor charged with performing an abortion would depend.

McGuire, in his written judgement, also said: 'This Ruling serves to illustrate the uncertainty of the present abortion laws of Queensland. It will require more imperative authority to effect changes if changes are thought to be desirable or necessary with a view to amending and clarifying the law.' At the time of writing, while the Queensland Law Reform Commission is reviewing the 1899 Criminal Code sections, this law remains in place.

The ACT decriminalised abortion in 2000, Victoria in 2008, Tasmania in 2013 and the Northern Territory in 2017. Western Australia made substantial changes to their law in 1998, and, in 1970, South Australia updated 1935 legislation, although some reform is still required in both these states. In New South Wales and Queensland, however, the law has still to emerge from the 19th century, when antibiotics and medical, surgical and anaesthetic procedures used today for abortion did not exist. Hopefully, law in both these states will soon be rewritten, so that women making the decision to terminate a pregnancy and women choosing to continue are regarded equally by the law, and all women's choices are regarded with respect by their healthcare providers.



The Frank Forster Library currently holds seven copies of Synopsis of Midwifery and Gynaecology by Aleck W Bourne, of which this third edition is the oldest, published in 1925.

References
1. Bourne A. A Doctor's Creed. London: Victor Gollancz, 1962.
2. Wainer J ed. Lost – illegal abortion stories. Melbourne, Melbourne University Press, 2006.

Reporting the facts on abortion

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Women Seeking Abortions Are Being Turned Away From Queensland's Hospitals. This July 2016 article was BuzzFeed News' foray into reproductive rights coverage in Australia. We have since published 109 stories in which we've spoken to patients, lawmakers, politicians, activists and doctors about access to abortion in Australia.

It is estimated that half of all pregnancies in Australia are unplanned and that half of those are terminated, but those figures are almost 30 years old.

We quickly found that this lack of current data, as well as the fact that access differs across states and territories, became an obstacle in every aspect of reporting on this issue.

South Australia is the only jurisdiction where women can easily access abortion services at a public hospital, at little to no cost, without fear of intimidation and harassment from religious picketers.

Access to abortion services can come down to pure luck because legality and affordability vary so greatly between and even within states. Counsellors in Queensland refer to the 'postcode lottery' in Brisbane, where some women mercifully fall within a hospital catchment that offers public provision.

Abortion remains in Queensland's criminal code and a woman outside of this area might have to rely on a not-for-profit counselling service to raise money for her termination, which can cost more than A$1000.

In New South Wales, where abortion remains a crime, patients might face anti-abortion picketers to access a termination, because unlike Tasmania, Victoria and the Northern Territory, the state has no safe access zones to protect patients from harassment.

Many politicians don't want to talk about an issue that won't win them votes. Many doctors don't want to talk about an issue that might attract abuse and many women don't want to forgo their privacy to talk about an issue that might have been a source of personal pain.

The practitioners we've spoken to have described the personal risks of providing abortions and what it is like to operate within the shadow of the law in states where the procedure is still written into 100-year-old criminal legislation. A nurse who is harassed by anti-abortion protesters on her way into the clinic; the only doctor who performs surgical abortions in the 2000km area north of Rockhampton and won't tell her friends what she does for a living; a regional obstetrician who was fined $180,000 for defaming religious picketers; a retired surgeon who was prosecuted after his Queensland clinic was raided in 1985 under the orders of a conservative premier.

Women have spoken about the barriers to access. A woman whose doctor told her abortion wasn't possible after nine weeks; a woman who waited days in hospital to terminate an unwanted pregnancy; a woman whose doctor told her abortion wasn't possible because it was a crime; a woman who cancelled her surgical abortion because she couldn't enter the clinic as her relative was protesting outside; a woman who paid more than $4000 to fly interstate for an abortion; a woman whose GP refused her a medical abortion because she was 'meant to be a mother'; a woman who explained how traumatic it can be to have a second-trimester abortion.

Pro-choice counsellors have explained how they sell tea towels and crowdsource funding via Facebook donations to fund abortions for homeless or disadvantaged women, who can't raise hundreds (or sometimes thousands) of dollars at short notice. Pro-choice activists have explained how they escort women into clinics so they don't get handed plastic fetal dolls by protesters.

We've learned that regional, rural and remote women can be seriously out of pocket after an abortion. One in ten women in Australia have to stay overnight in the town they've travelled to for the termination, drastically increasing the cost. Medical abortion should cost an Australian patient $38.80, as they are subsidised by the Pharmaceutical Benefits Scheme, but can cost women in regional areas upwards of $700 for the two pills.

A lot has happened since we started covering this issue. A push to decriminalise abortion failed in Queensland parliament and another failed in New South Wales parliament. A law that decriminalised abortion and legalised medical abortion passed through Northern Territory parliament. Religious protester Kathy Clubb became the first person arrested, tried, convicted and ultimately fined under Victoria's safe access zone laws. A bill to introduce similar zones in New South Wales was introduced into that state's parliament. During the internal parliamentary inquiries and external public debate on legislative change, misinformation defined much of the discourse.

Much of our work has involved mythbusting and fact-checking resources distributed by anti-abortion groups or uninformed commentary from politicians. In the past 18 months, a state MP has blamed abortion for lost tax revenue, a senator told BuzzFeed News women were just too 'shy' to 'reach out' and ask about options other than abortion and another politician introduced a motion against anti-domestic violence organisation White Ribbon for supporting reproductive rights. During Queensland's decriminalisation debate, a Catholic archbishop compared a state with legalised abortion to Nazi Germany.

We repeatedly busted falsehoods about second-trimester abortion being common and easy to obtain.

We asked experts about newspaper and radio advertising campaigns from religious groups in Queensland, which claimed, among other things, that decriminalisation would allow 'abortion at ANY stage of pregnancy, for ANY reason'.

We fact-checked a motion by One Nation turned independent senator Fraser Anning that called on the Federal government to fund compulsory counselling for women considering abortion. We broke down why Queenslanders were getting unsolicited robocalls warning that people would 'die' if they voted for Labor. We combed through materials handed to patients entering clinics in Western Australia which pedalled the myth that abortion causes breast cancer.

As most of the information distributed about abortion is done so by anti-abortion groups, there's a lot of misunderstanding about the procedure in our BuzzFeed News comments section. Some of these ideas include: women have complete control over when and where they fall pregnant, women are using abortion as contraception, and the termination rate would drop if the procedure cost more.

From the research and interviews we've undertaken since July 1016, we have begun to untangle an uncomfortable issue and trace the social and political threads that impede access to abortion in Australia.

The next step in our reproductive rights coverage is to partner with service providers and support services to undertake an ambitious data project aiming to provide a better picture of access to abortion services across Australia.

We've made a commitment to provide accurate and informative coverage of access to abortion and attempts at law reform. We want other media outlets to join us. To do that, they need access to the facts.

With the cooperation of doctors and service providers, as well information obtained under freedom of information, we think we can start to build a decent picture of access to abortion in Australia. This won't only allow more accurate reporting, it will also ensure the ongoing debate around access and decriminalisation is rooted in the facts.

To find out more about the project or to get involved, contact us at Gina.Rushton@buzzfeed.com and Marni.Cordell@buzzfeed.com.

RANZCOG Media Award of Excellence

Established in 2012, the RANZCOG Media Award of Excellence was introduced in recognition of the role the media play in influencing how and what health information women and decision-makers consume. Media professionals are able to nominate themselves or a colleague for the annual award and with each year the pool of submissions continues to grow.

This year, two Sydney-based journalists were awarded. Gina Rushton, BuzzFeed Australia journalist, for her leading coverage of abortion issues in Australia, and Cat Rodie, a freelance journalist, for breaking the silence around the topic of birth injuries.

Through this initiative, the College is able to acknowledge exemplary reporting of O&G issues and women's health, create connections with the media and demonstrate a commitment to encouraging balanced and accurate reporting.

Nominations for the 2017–18 Media Award of Excellence will open in September.

Case report

Bowel obstruction in gynaecology

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A 47-year-old pre-menopausal woman presented describing severe pain in the left iliac fossa and abdomen. This was associated with nausea and vomiting but normal bowel movements. The patient was multiparous (normal vaginal deliveries) and was using the combined oral contraceptive pill to manage irregular and heavy menstrual bleeding of a known multifibroid uterus. Cervical screening was normal and up to date. Relevant history featured multiple sclerosis managed by natalizumab. The patient had never undergone any abdomino-pelvic surgery.

Clinical examination revealed normal vital signs but a tender abdomen (most prominent in the left iliac fossa). There were no features of peritonism. Bowel sounds were present, noted to high-pitched and tinkling. A CT scan of the abdomen and pelvis suggested a small bowel obstruction. A clear transition point was identified, associated with a 25cm closed loop segment of small bowel (Figure 1). Additional CT findings were of abnormal and nodular appearance to the omentum and pelvic peritoneum, but normal appearance of the ovaries bilaterally. Ascites was not present.

The patient was admitted and underwent a mid-line laparotomy in acute management of small bowel obstruction. Inspection of the abdominal and pelvic peritoneal surfaces and organs revealed innumerable soft tissue implants, each measuring less than 1cm in size. Multiple uterine fibroids were identified and the ovaries appeared macroscopically normal. Particularly involved with tumour were small and large bowel serosa, as well as the recto-sigmoid mesentry (Figure 2).

The site of the closed-loop small bowel obstruction was clearly identified. The tumour had eroded a 3cm defect in the recto-sigmoid mesentry, through which a loop of small bowel had become incarcerated (Figure 3). A gynaecologic oncologist was invited for intra-operative consultation. Disseminated leiomyomatosis was clinically suspected and supported by frozen section. A 10cm segment of small bowel was resected with functional end-to-end anastomosis, after being reduced through the mesenteric defect. This defect was closed with interrupted sutures.

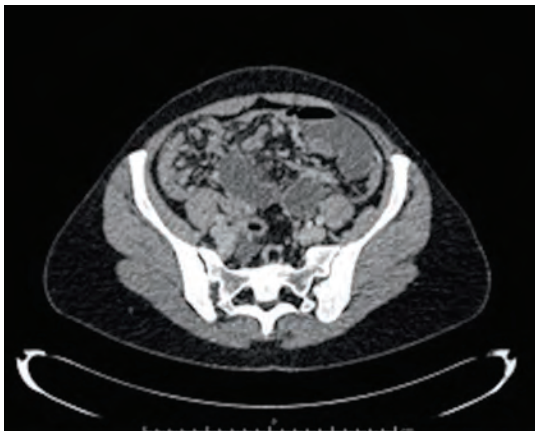

Figure 1. Small bowel obstruction.
CT scan demonstrating small bowel obstruction with transition point and diffuse peritoneal disease.

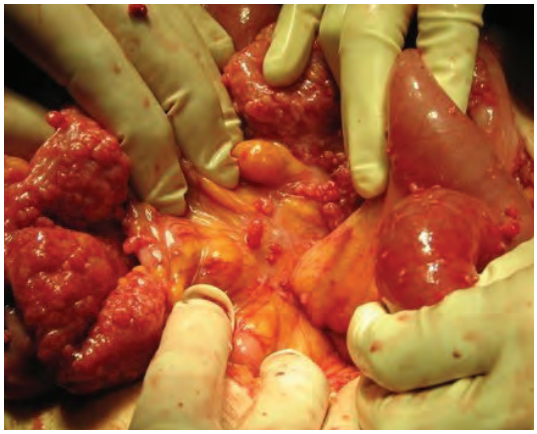

Figure 2. Disseminated leiomyosis peritoneii.
Innumerable smooth muscle tumourlets can be seen scattered across peritoneal surfaces.

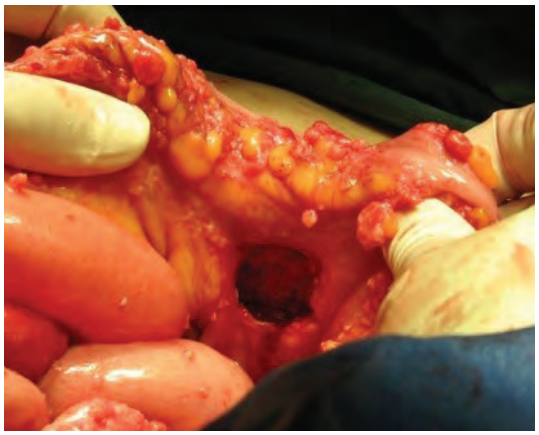

Figure 3. Internal herniation.
Note the recto-sigmoid defect responsible for the closed-loop small bowel obstruction.

Final histologic examination confirmed disseminated leiomyomatosis peritoneii (DLP). The patient's post-operative progress was poor, featuring persistent pain and prolonged ileus. Total parenteral nutrition was commenced. On day nine post-operatively, the patient demonstrated acute deterioration, with increased pain and tachycardia. CT demonstrated a markedly distended caecum through to descending colon, therefore, the very rare occurrence of a closed loop (mechanical) large bowel obstruction. Emergency operative management was undertaken by a general surgical team who noted extensive leiomyomatous adhesions cicatrising the sigmoid deep in the pelvis. A venting ascending colostomy was performed.

The patient was discussed at a gynae-oncology tumour board meeting and was commenced on a gonadotropin-receptor agonist (Goserelin). She made a slow, but successful, post-operative recovery. Six months from presentation, the patient underwent elective surgical cytoreduction. This procedure involved hours of adhesiolysis, extended hysterectomy, bilateral salpingo-oophrectomy, high anterior resection, ileocolic resection and colostomy reversal. She is now well and is the subject of regular follow up by general surgery and gynaecologic oncology. She has experienced significant menopausal symptoms that have been successfully managed via non-hormonal means.

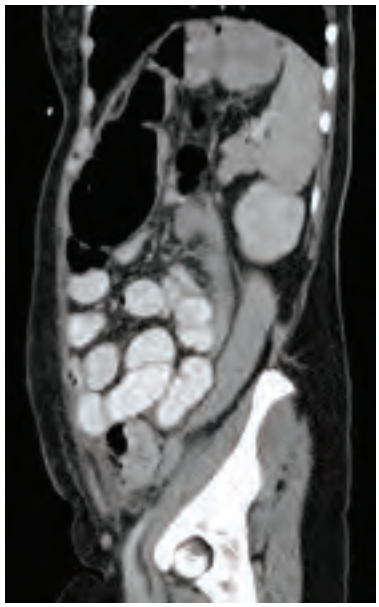

Figure 4. Mechanical large bowel obstruction. CT scan demonstrating a closed loop large bowel obstruction, secondary to extensive leiomyomatous adhesions cicatrizing the rectum and sigmoid.

Discussion

Histologically benign, DLP is a condition featuring multiple smooth muscle tumourlets scattered across peritoneal surfaces. These lesions are both micro- and macroscopically identical to their uterine counterparts (leiomyomata or fibroids). The macroscopic appearance is similar to metastatic ovarian or peritoneal carcinoma and can pose a significant diagnostic dilemma. Histologic examination demonstrates bland smooth cells with low proliferative activity, no significant atypia and no geographic tumour necrosis.[1] As seen in our case, intra-operative frozen section and the clinical experience of a gynaecologic oncologist can be beneficial in making the diagnosis.

A rare entity, first described by Wilson and Peale in 1952,[2] fewer than 200 cases of DLP have been described. The majority of cases feature an indolent (or benign) clinical course where discovery of the disease is incidental, rarely requires acute management, or is found to invade surrounding structures. Most cases are discovered at the time of surgery performed for an unrelated condition (for example, caesarean section). Locally destructive DLP, as seen in our case, or DLP as the aetiological agent in small or large bowel obstruction, is exceedingly rare.[3] The possibility of malignant (or sarcomatous) transformation of DLP (estimated at less than 5 per cent risk) is also rare.

Most cases of DLP arise in pre-menopausal women. Multiple aetiologic factors have been identified, including transcoelomic metaplasia (as proposed in the development of endometriosis) and hormonal stimulation (pregnancy, oestrogen-secreting tumours, assisted reproductive technologies, long-term contraceptive use). Importantly, intraperitoneal seeding of morcellated benign uterine fibroid tissue has also been implicated.[4,5]

Treatment options are poorly described and there is no consensus regarding management. The hormonally sensitive nature of the disease necessitates removal of oestrogen exposure, including cessation of hormonal contraceptives, avoidance of hormonal replacement therapy and/or induction of menopause (surgically or via the use of gonadotropin-receptor antagonists). The requirement for acute or cytoreductive surgical intervention is rare, but has been reported in a few cases similar to ours, where the disease has invaded local structures.

Conclusion

Our report describes a case of DLP resulting in significant surgical morbidity, requiring radical surgery.[3,6] This case is a clear example of the potential for serious sequelae arising from disseminated benign disease and describes a novel management strategy employing both medical and surgical treatment modalities.

References

1. Crum CP, Lee KR, Nucci MR. Diagnostic gynecologic and obstetric pathology. Elsevier Health Sciences; 2011.
2. Willson JR, Peale AR. Multiple peritoneal leiomyomas associated with a granulosa-cell tumor of the ovary. *AJOG* 1952;64(1):204-8.
3. Ghosh K, Dorigo O, Bristow R, Berek J. A radical debulking of leiomyomatosis peritonealis disseminata from a colonic obstruction: a case report and review of the literature. *Journal of the American College of Surgeons* 2000 Aug;191(2):212-5.
4. Lete I, González J, Ugarte L, et al. Parasitic leiomyomas: a systematic review. European *Journal of Obstetrics & Gynecology and Reproductive Biology* 2016 Aug 1;203:250-9.
5. Cohen A, Tulandi T. Long-term sequelae of unconfined morcellation during laparoscopic gynecological surgery. *Maturitas* 2017 Mar 1;97:1-5.
6. Ramos A, Fader AN, Roche KL. Surgical cytoreduction for disseminated benign disease after open power uterine morcellation. *Obstet Gynecol.* 2015 Jan;125(1):99-102.

Case report

Ectopic pregnancy masquerading as a molar pregnancy

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A 22-year-old nulliparous, morbidly obese woman with a history of infertility was referred to the gynaecology outpatient clinic with PCOS. After losing 20kg within a couple of months of lifestyle changes, her weight dropped to 134kg. Then, she was commenced on treatment with metformin 850mg and clomiphene 50mg a day, on days 3–7 of her menstrual cycle, with ongoing weight management measures. Following one cycle of clomiphene, her progesterone levels indicated successful ovulation.

One month after her last review, she was referred by her GP to an Early Pregnancy Assessment Service (EPAS) clinic at seven weeks of pregnancy (based on the last day of her menstrual period), with a suspected molar pregnancy. A transvaginal ultrasound two days prior to the EPAS assessment revealed diffuse 25mm thickening of the endometrium with multiple cystic spaces, raising the possibility of a molar pregnancy (Figure 1). Her serum β-hCG was 14025 IU/L. A repeat scan reconfirmed gestational trophoblastic disease without evidence of adnexal pathology. The patient showed no signs or symptoms of ectopic pregnancy. Although her β-hCG level was not typical for a molar pregnancy, a suction and evacuation was booked due to presumed atypical presentation. Tissue samples were sent to histopathology. She was discharged the same day with EPAS follow-up and a supply of β-hCG level request slips.

The patient self-presented to A&E six days after uneventful dilatation and curettage with abdominal cramps and moderate vaginal bleeding. Her β-hCG level was 14490 IU/L. She was admitted with suspected retained products or persistent molar pregnancy, with a plan to do an ultrasound the next morning and follow up the histopathology report.

Transvaginal ultrasound showed no endometrial abnormality to indicate ongoing molar pregnancy or retained products of conception. A heterogeneous mass was found superiorly in the left adnexa with a small amount of free pelvic fluid. This may have indicated an ectopic pregnancy though no fetal pole was visible. There was a collapsed gestational sac within the endometrial cavity.

The patient's haemoglobin had dropped since the D&C from 107g/L to 95g/L. Her histopathology indicated only hypersecretory endometrium and decidua, no evidence of molar tissue.

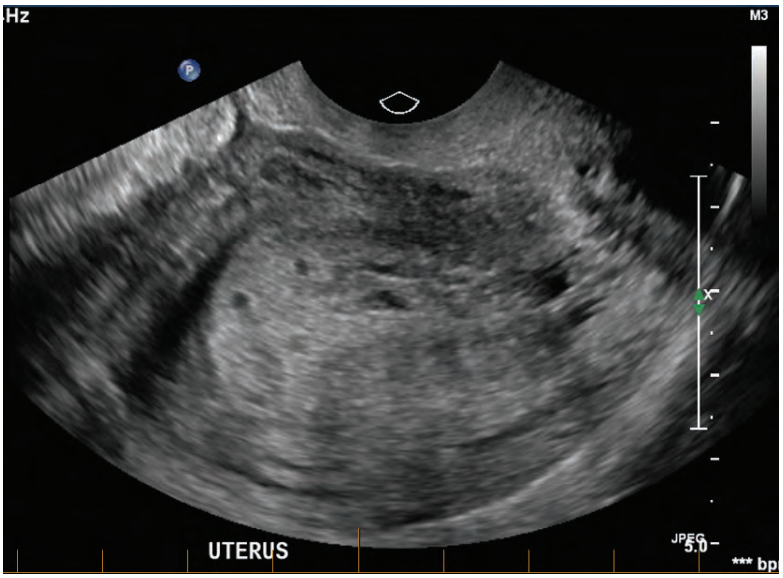

Figure 1. Ultrasound findings consistent with gestational throphoblastic disease.

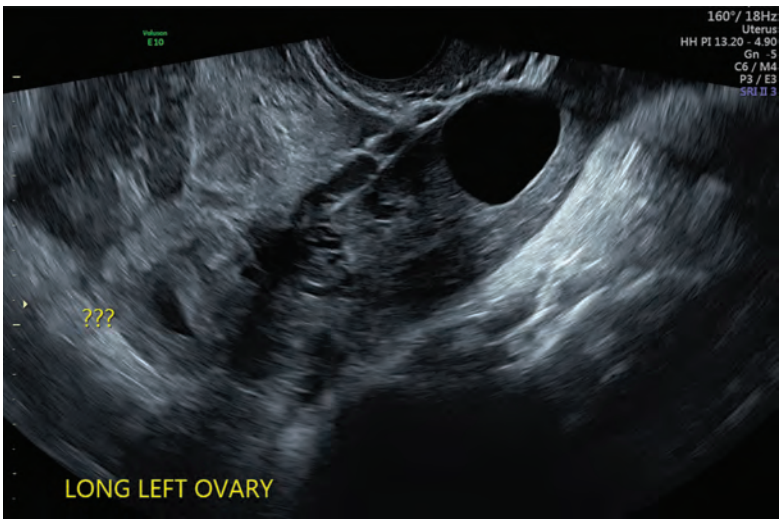

Figure 2. Ultrasound findings suggestive of left tubal ectopic pregnancy.

After counselling, the patient consented to surgical treatment for suspected ectopic pregnancy. Two hours later, she was taken to the emergency theatre for laparoscopic treatment of the ectopic pregnancy. During the procedure, active bleeding from the ectopic site was found and a left salpingectomy was performed. Estimated blood loss was more than 2L.

The patient recovered well and was discharged with iron supplements after four units of packed red blood cells (PRBC) transfusion. At follow up one week after the laparoscopy, her serum β-hCG was negative and skin wounds were healing normally. Due to personal issues, she decided to take a break from fertility treatment.

This case presents an unusual incidence of ectopic pregnancy, where possible molar pregnancy was a red herring. Two scans were done in different radiology departments and both were highly indicative of a molar pregnancy, without suggestion of extrauterine pathology. The patient had presented asymptomatic with scans suggestive of molar pregnancy, even though the β-hCG level was not typical of molar pregnancy. She was booked and underwent suction and evacuation procedure. This demonstrates how difficult it is to accurately monitor an early pregnancy in a morbidly obese patient.

Retrospectively, clinicians should always repeat the β-hCG level 48 hours post-initial levels of hormone. Doing this would have helped to diagnose ectopic pregnancy, leading to further investigations and management at first encounter.

References

1. Ectopic Pregnancy Guidelines. Health.qld.gov.au. 2018 [cited 27 January 2018]. Available from: www.health.qld.gov.au/__data/assets/pdf_file/0023/143906/f-epl-ectopic.pdf.
2. Gaillard F. Ectopic pregnancy | Radiology Reference Article | Radiopaedia.org [Internet]. Radiopaedia.org. 2018 [cited 27 January 2018]. Available from: https://radiopaedia.org/articles/ectopic-pregnancy.

The leg-up

Your regular legal update to keep you informed on current medicolegal issues in the practice of obstetrics and gynaecology

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General Medical Council statement on Dr Bawa Garba

On 28 March 2018, Lord Justice Simon granted Dr Bawa Garba permission to appeal the decision by the High Court that led to her erasure from the medical register. Dr Bawa Garba was convicted of gross negligence manslaughter for her role in the death of six-year-old Jack Adcock. The Court acknowledged there were system failures and that Dr Bawa Garba was unsupported by seniors during a busy shift, after her recent return from parental leave. However, the Court found that the errors she made, ultimately leading to Jack's death, were so negligent, despite contributing factors, that it amounted to manslaughter.

The subsequent tribunal case, which was asked to consider whether Dr Bawa Garba's fitness to practice was impaired and whether sanctions were appropriate, found that a 12-month suspension order was indicated. The General Medical Council (GMC) appealed the decision, arguing that a criminal conviction for gross negligence is incompatible with being a doctor. They argued that more serious sanctions, such as erasure, are required in order to maintain public confidence in the profession. They also argued that the tribunal revisited findings of the Criminal Court, particularly with respect to contributing factors, and that this was unlawful. The High Court agreed with the GMC and this led to Dr Bawa Garba being struck off the register.

Following widespread outrage from the medical community, including a vote of no confidence in the GMC at a GP conference, a review of the role of gross negligence manslaughter, and a successful fundraising campaign to support Dr Bawa Garba's case, an application for a second appeal was launched. The application met the test, according to Lord Justice Simon, which requires that the appeal not only has a 'real prospect of success', but that it raises an important point of principle or practice, or involves a compelling reason for the Court of Appeal to hear it.

The appeal is listed for a full hearing by three judges. The issues to be addressed are:

- Whether the GMC and Divisional Court are correct that it is unlawful for the Medical Practitioners Tribunal (MTC) to revisit the findings of the Criminal Court
- Whether a doctor convicted of gross negligence requires serious action be taken to maintain public confidence in the profession and its standards
- Whether a conviction of gross negligence manslaughter is fundamentally incompatible with being a doctor

The British Medical Association welcomed the decision and will apply to intervene in the appeal in order to assist the Court. The appeal is expected to occur before the end of July 2018.

Senate report on vaginal mesh

The Australian Senate inquiry report on transvaginal mesh implants was released in March 2018. The purpose of the inquiry was to: identify the number of Australian women adversely affected by transvaginal mesh surgery; consider the information and support available to women undergoing transvaginal mesh surgery; consider the information provided to doctors and surgeons who recommend and undertake transvaginal mesh surgery; and examine the role of the Therapeutic Goods Association (TGA) in approving and monitoring mesh devices in Australia.

One of the disturbing aspects of the report are the accusations by women against some medical professionals, saying they had not consented to the insertion of mesh, from which they now suffer ongoing complications. In their response, the committee of inquiry encouraged women not to accept 'unprofessionalism' from doctors and to consider reporting their concerns. RANZCOG also strongly encourages women with complaints about their care to contact relevant regulators in their jurisdictions.

The report also considered the role of the TGA and its processes for approval and monitoring of medical devices. While the committee of inquiry accepted

that assessment and approval of medical devices is a continually evolving process, it found that criticisms of the delay in regulatory response towards emerging evidence were justified.

The report culminated in 13 recommendations calling for greater oversight and improved systems, in order to prevent not only the extent of harm caused by vaginal mesh from happening in future, but also harm caused by delays in recognition and action.

The committee concluded by emphasising, to the women who came forward with their stories, that they have been heard and thanking them for their courage and persistence. It is clear that too many women were left feeling unheard and uncared for. It has resulted in a loss of trust in some members of the medical profession that must be rebuilt. Implementation of these recommendations ensures greater oversight of the device-manufacturing industry and individual practice. Measures such as these can help to rebuild women's faith in the care that they receive. As a specialty, we should continue to work towards listening, communicating effectively and providing women with the best possible experience of care.

Female genital mutilation in Malaysia

The practice of female genital mutilation/cutting (FGM/C) in Malaysia has drawn international criticism following constructive dialogue at the 69th session of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), in February 2018. Unlike many other countries, including some Muslim countries, the practice is not illegal in Malaysia. When Malaysia was questioned about it's failure to criminalise FGM/C, a delegate disagreed with comments made by Ismat Jahan from Bangladesh that the practice was not Islamic, stating that FGM/C is part of Islamic teaching and should be observed by Malaysian Muslims. The Malaysian Ministry of Health stated that it was a harmless procedure. Malaysia ratified CEDAW in 1995.

The practice of FGM/C remains prevalent within communities in Africa and some areas of India, Asia and the Middle East. It is thought that 100–140 million women worldwide have been subjected to FGM/C. The practice can vary significantly from culture to culture and there are four basic categories: partial or total clitoridectomy (Type I); excision of the labia minora and/or majora (Type II); infibulation that involves narrowing of the vaginal opening by cutting and sewing up the labia minora to form a thick scar tissue over the genital area, with a small opening for urine and menstrual bleeding (Type III); and all other 'harmful procedures' to the genital area, including piercing and cauterisation (Type IV). The most common forms of FGM/C practised in Malaysia are types I and IV.

In Australia, each state has enacted legislation (for example, Crimes Act 1958 [Vic] s32) specifically targeting FGM/C and making it an offence to perform the practice on a female under 18 years of age. Legislation excludes genuine medical and sexual reassignment procedures performed by a medical professional, including any considerations other than medical welfare and the relief of physical symptoms. In addition, it is an offence in all states to remove a child from Australia with the intention to procure a female circumcision elsewhere. Finally, consent is unanimously no defence, whether by the subject, parent or guardian. The language of the legislation places onus on those around the subject of the procedure to prevent the offence from occurring. The New South Wales Act makes it an offence to aid, abet, counsel and procure a procedure for another person. While the Victorian Act is not as clear, the legislation aims to oblige others to save the individual from succumbing to external pressures.

In Malaysia, a 2016 survey found that only four per cent of Muslim women had not been circumcised, while an astonishing 88 per cent of Muslim women surveyed reported having been circumcised when they were young (eight per cent of respondents were unsure if they had been circumcised).[1] The practice has recently been medicalised and is now performed by doctors in clinics and hospitals. The 2009 fatwa, which astonishingly, shifted the practice away from being 'recommended practice' to 'obligatory practice' created a dilemma for doctors. This marked a dramatic shift away from the fatwa convened by Dar al-Ifta al-Misriyyah, a high-ranking Egyptian Muslim institution, in 2006, that found the custom of FGM/C was deplorable and had no justification in Islam. Malaysia supported a move to medicalise the practice with the implementation of 'harm minimisation strategies' that include better practices and hygiene, and fewer long-term complications as less tissue is removed. 'Harm minimisation strategies' do not address the deeply entrenched gender inequalities that lead to FGM/C including:

- The need for social acceptance to ensure girls have marriage prospects and economic and social security
- The belief that the removal of all 'semblance of male parts' is considered 'beautiful and feminine'
- The promotion of sexual restraint to protect the virginity of girls before marriage and attempt to ensure fidelity in marriage

Malaysia is in conflict with its international obligations and continues to use religious justifications for cultural practices that are not without harm regardless of 'harm minimisation strategies'.

Reference

1. Khalid S, et al. The study of knowledge, attitude and practice towards female circumcision among female patients at O&G outpatient department, hospital Ampang, Selangor, Malaysia. *Ulum Islamiyyah: The Malaysian Journal of Islamic Sciences.* 2017; vol. 21, pp.15-24.

Q&A

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

Q Should we give antenatal corticosteroids to women with diabetes prior to planned late preterm delivery?

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A Diabetes mellitus in pregnancy, both pre-gestational and gestational, is increasingly common, and late preterm birth among these women is more common than in the general population. Antenatal corticosteroids are of clear benefit prior to preterm birth, but carry potential risks to mother and neonate in the presence of diabetes. As with any intervention in pregnancy, the balance of these benefits and risks must be considered prior to a decision to prescribe this therapy.

What are the benefits of antenatal corticosteroids?

Antenatal corticosteroid administration has been known to benefit the preterm infant since the sentinel trial of Liggins and Howie was reported in 1972.[1] These initial observations have been conclusively replicated, with significant reductions in respiratory distress syndrome (RR 0.76), requirement for ventilatory support (RR 0.68), intraventricular haemorrhage (RR 0.55), necrotising enterocolitis (RR 0.50), and neonatal mortality (RR 0.69), in preterm neonates who receive a single course of corticosteroids.[2] While initial studies demonstrated benefit for infants born before 34–35 weeks' gestation, more recently, the Antenatal Late Preterm Steroids (ALPS) trial showed further benefit even up to 37 weeks, with a 20 per cent reduction in the requirement for respiratory support compared to placebo.[3,4] One case of severe respiratory distress can be prevented for each 58 women given corticosteroids prior to late preterm birth.

What are the risks of antenatal corticosteroids?

In high-resource settings, corticosteroid administration in otherwise uncomplicated pregnancies confers benefit without apparent risk at gestations up to 34 weeks.[1] However, neonatal hypoglycaemia has been reported in infants exposed to antenatal corticosteroids in the late preterm period,[3] likely related to transient steroid-induced maternal hyperglycaemia with compensatory fetal hyperinsulinaemia, in line with the Pedersen hypothesis.[5] This is generally mild and not associated with a prolonged hospital stay beyond what is normally required for a late preterm neonate.[3]

In women with diabetes, however, corticosteroid administration is not without risk for the mother or neonate. The glucocorticoid activity of steroid preparations at high doses can precipitate diabetic ketoacidosis in women with all forms of diabetes mellitus, if careful attention to hyperglycaemia and insulin therapy is not paid.[6] Also, the maternal-fetal hyperglycaemia provoked by steroid administration just prior to birth may increase the incidence of neonatal hypoglycaemia and respiratory distress.[3,7]

What is the effect of diabetes on neonatal respiratory outcomes?

Infants of women with diabetes are at greater risk of severe neonatal respiratory distress syndrome compared to those of normoglycaemic mothers.[8] Hyperinsulinaemia, as seen in maternal-fetal hyperglycaemia, directly impairs surfactant production and is likely to be a significant mechanism underlying respiratory distress in infants of diabetic mothers.[9] Pre-labour caesarean section is more commonly required in the setting of diabetes, and is associated with a doubling in neonatal respiratory distress among late preterm infants independent of other contributors.[10]

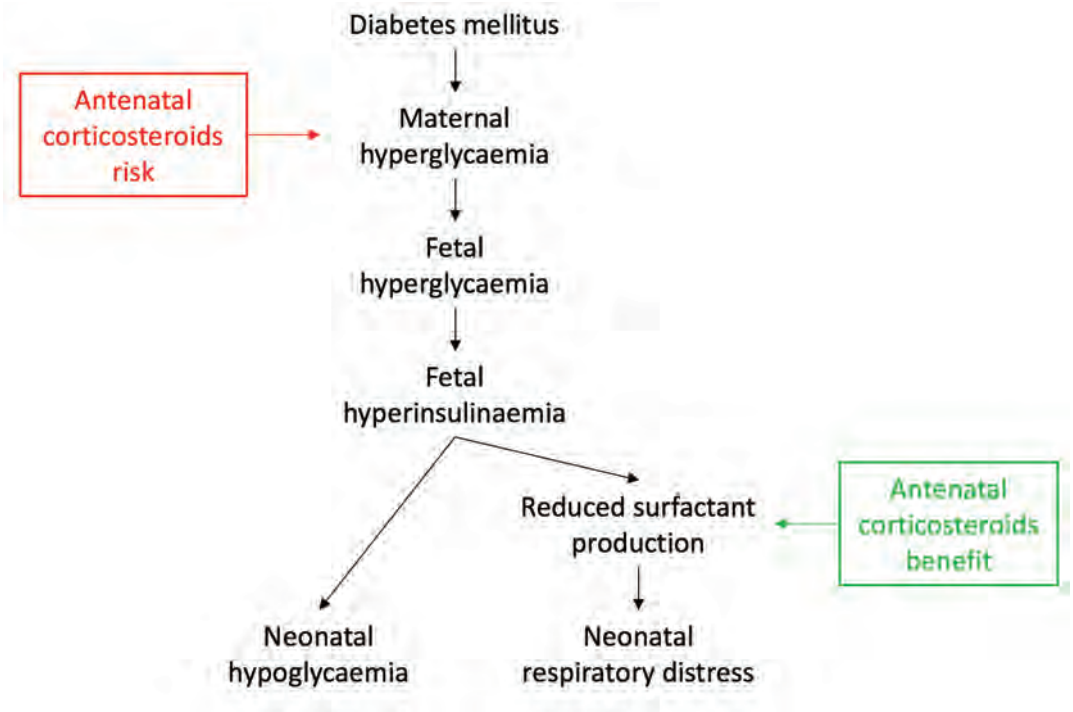

Figure 1. Mechanism of neonatal respiratory distress and hypoglycaemia in diabetes in pregnancy and the potential benefits and harms of antenatal corticosteroids.

What is the role for antenatal corticosteroid use in women with diabetes prior to late preterm birth?

To date, there has been no randomised trial of antenatal corticosteroids in this setting. A reduction in neonatal respiratory distress may be inferred from the results of studies such as ALPS, given the high risk of the outcome in this group, but women with pre-gestational diabetes were excluded from this and other trials due to concerns of potential adverse effects. Corticosteroids can have conflicting physiological effects in infants of women with diabetes, with the potential that beneficial effects on surfactant production could be outweighed by the suppressive influence of hyperinsulinaemia in steroid-induced hyperglycaemia (see Figure 1).

Future studies will examine the role of antenatal corticosteroids in specific circumstances, such as prior to elective caesarean delivery, as well as the dose and route of steroid administration. In women with diabetes who are given corticosteroids, optimal post-steroid insulin management is still to be determined.

In the interim, in the absence of specific evidence to guide clinical practice, clinicians must consider the individual characteristics of each woman and fetus, such as gestation, quality of glycaemic control, planned mode of birth, and the risk of maternal complications in their prescribing decisions.

References

1. Liggins GC, Howie RN. A controlled trial of antepartum glucocorticoid treatment for prevention of the respiratory distress syndrome in premature infants. *Pediatrics* 1972;50(4):515-25.
2. Roberts D, Brown J, Medley N, Dalziel SR. Antenatal corticosteroids for accelerating fetal lung maturation for women at risk of preterm birth. *The Cochrane Database of Systematic Reviews*. 2017;3:Cd004454.
3. Gyamfi-Bannerman C, Thom EA, Blackwell SC, Tita ATN, Reddy UM, Saade GR, et al. Antenatal betamethasone for women at risk for late preterm delivery. *NEJM* 2016;374(14):1311-20.
4. Saccone G, Berghella V. Antenatal corticosteroids for maturity of term or near term fetuses: systematic review and meta-analysis of randomized controlled trials. *BMJ* 2016;355.
5. Pedersen J. Diabetes and pregnancy: blood sugar or newborn infants [PhD thesis]. 1952, Copenhagen (Denmark), Danish Science Press.
6. Bedalov A, Balasubramanyam A. Glucocorticoid-induced ketoacidosis in gestational diabetes: sequel of the acute treatment of preterm labor. *Diab Care* 1997;20(6):922-4.
7. Piper JM, Xenakis EM, Langer O. Delayed appearance of pulmonary maturation markers is associated with poor glucose control in diabetic pregnancies. *J Matern Fetal Med* 1998;7(3):148-53.
8. Mortier I, Blanc J, Tosello B, Gire C, Bretelle F, Carcopino X. Is gestational diabetes an independent risk factor or neonatal severe respiratory distress syndrome after 34 weeks of gestation? A prospective study. *Arch Gynecol Obstet* 2017;296(6):1071-7.
9. Stubbs WA, Stubbs SM. Hyperinsulinism, diabetes mellitus, and respiratory distress of the newborn: a common link? *Lancet* 1978;1(8059):308-9.
10. Indraccolo U, Pace M, Corona G, Bonito M, Indraccolo SR, Di Iorio R. Cesarean section in the absence of labor an d risk of respiratory complication in newborns: a case-control study. *J Matern Fetal Neonatal Med* 2017;1-7. doi: 10.1080/147670528.2017.1401999 [Epub].

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WOMEN'S HEALTH

Journal Club

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

HPV vaccine after 10 years

Widespread vaccination against human papilloma virus (HPV) commenced in Australia in 2007, initially in 12 to 13-year-old girls, with a catch-up program aimed at 14 to 26-year-old women continuing until 2009. The program involved three doses of the quadrivalent Gardasil vaccine against HPV types 16, 18, 6 and 11. This recent Australian study reports the effect of HPV vaccination on the prevalence of HPV infection in women aged 18–35 in 2015.[1] In the sample studied, the three-dose vaccination rate was 65 per cent in women aged 18–25 and 40.3 per cent in those aged 25–35. Prevalence of HPV infection in the types covered by the vaccine decreased from 23 per cent in 2005–2007 prior to the program's introduction to 1.5 per cent in 2015 among women aged 18–24 years, and from 12 per cent prior to the program to 1.1 per cent in 2015 among those aged 25–35 years. These large decreases in HPV infection have been observed despite many women not receiving three doses. The authors speculate that this may be due to efficacy of the vaccine after fewer than three doses and herd immunity. These conclusions are supported by the second study outlined below.

Outside of Australia, HPV vaccination programs have utilised a variety of vaccines, including the quadrivalent vaccine used in Australia, as well as bivalent and nonavalent (nine HPV types) vaccines. In each case, the vaccines provide coverage against HPV types 16 and 18, which are the types most commonly associated with cervical cancer. A recent review compared the experience of all three vaccines since their introduction 10 years ago.[2] Among women aged 15–26 years, both the bivalent (Cervarix) and quadrivalent vaccines showed greater than 94 per cent vaccine efficacy against HPV 16 and 18 infection at six months post-vaccination. Data were not reported for the nonavalent vaccine (Gardasil 9). The disease endpoint of cervical intraepithelial neoplasia grade 2 or worse (CIN 2, CIN 3, adenocarcinoma in situ [AIS], adenocarcinoma and carcinoma) caused by any HPV type was prevented equally well by both Gardasil 9 and Cervarix. Gardasil, on the other hand, was significantly less protective than Cervarix against CIN 2 + from any HPV type. For the CIN 3 + endpoint caused by any HPV type, Cervarix provided 93 per cent protection, significantly higher than Gardasil. All three vaccines led to a decreased need for colposcopies and cervical excision procedures. On a global basis, the authors suggest there was no significant benefit in revaccinating women who had already received HPV vaccine. They also suggest that a single dose of Cervarix provided robust protection against HPV 16 and 18 and may provide the most effective strategy in low-income settings.

References
1. Machalek DA, Garland SM, Brotherton JML, Bateson D, et al. Very low prevalence of vaccine human papilloma virus (HPV) types among 18 to 35 year old Australian women, nine years following implementation of vaccination. *J Infect Dis.* 2018 Feb 7. doi: 10.1093/infdis/jiy075.
2. Harper DM, DeMars LR. HPV vaccines – a review of the first decade. *Gynecologic Oncology* 146 (2017) 196–204. Retrieved from: http://dx.doi.org/10.1016/j.ygyno.2017.04.004.

HRT and depression

Women report an increased incidence of depressive symptoms during the menopause. This study reported a randomised controlled trial of the effect of combined hormone replacement therapy (HRT) on depressive symptoms. 172 peri- or postmenopausal-aged women between 45 and 60 were randomised to receive either continuous transdermal estradiol with intermittent oral progesterone, or placebo. The Center for Epidemiologic Studies Depression Scale (CES-D) was used to assess symptoms every two months for a year. Women in the HRT group reported significantly less total depression compared to the placebo group. The positive effect of HRT on depression was moderated by other factors. The significant benefit of HRT on mood was seen in women in early menopause, but not in late menopause or postmenopausal women. In addition, women with a greater number of stressful life events in the six months preceding the trial experienced significantly greater benefit to their mood as a result of HRT, compared to women with less stressful events. Although this was a small trial, results provide evidence of additional benefits of HRT for some women.

Reference
1. Gordon JL, Rubinow DR, Eisenlohr-Moul TA, Xia K, Schmidt PJ, Girdler SS. Efficacy of transdermal estradiol and micronized progesterone in the prevention of depressive symptoms in the menopause transition: a randomized clinical trial. *JAMA Psychiatry*. Published online January 10, 2018. doi:10.1001/jamapsychiatry.2017.3998.

Core Outcome Sets: How they can benefit you

Dr J Oliver Daly
BSc(Hons), MBBS, FRANZCOG, CU

Core Outcome Sets (COS) can help us determine which outcomes to measure and how to measure them, when assessing the benefits and risks of interventions for specific conditions. COS are developed through a systematic process, identifying an inventory of potential outcomes that are refined to a minimum set of important outcomes using consensus-building methods, involving representative groups of stakeholders, including patients. Once the COS is defined, a similar process is conducted to achieve a consensus on how to measure these outcomes and which instruments are truthful, discriminatory and feasible.[1] Each stage of COS development is then disseminated through journals to researchers and other consumers.

Once developed, the consistent use of COS may benefit researchers, who will be able to compare and aggregate their data with other studies, as well as ensuring their findings are relevant to clinicians and patients. The benefits of COS have been observed in rheumatology research, with 70 per cent of intervention trials reporting all COS measures, including patient reported outcomes, developed through the Outcome Measures in Rheumatology (OMERACT) initiative.[2]

How can COS benefit you?

The main purpose of COS is to ensure the inclusion of consistent outcomes when designing primary studies. By including the outcomes of a COS relevant to the condition studied, researchers can be confident they have included important outcomes, and depending on the COS, be guided on how to define and measure those outcomes. Similarly, when assessing studies and systematic reviews that include the COS in their outcomes, it can be assumed that the important and relevant outcomes have been reported regarding the intervention effect.

What COS are currently available and how were they developed?

There are a number of women's health conditions for which COS[3] have been developed:

- Prevention of preterm birth (13 core outcomes)
- Pregnant women with epilepsy (29 core outcomes)
- Pre-pregnancy care for women with pre-gestational diabetes (17 core outcomes)
- Reconstructive breast surgery (11 core outcomes)
- Maternity care (48 core outcomes)

In the COS, 'prevention of preterm birth',[4] the initial inventory of outcomes was based on a systematic review of primary outcomes used in randomised control trials.[5] This was expanded on by surveys of stakeholder groups including clinicians, patient representatives and patient advocacy groups, as well as semi-structured interviews with parents. Starting with this inventory, a two-round iterative Delphi survey process was used to establish a consensus, based on a process determined a priori that defined group composition, anonymity for respondents, grading importance of outcomes, participant feedback, criteria for consensus and management of bias. The large consultation group included 337 obstetricians, 152 midwives, 175 researchers, 75 neonatologists, and a large number of parents through the advocacy groups. For each round, participants ranked the potential outcomes from limited to critical importance using a nine-point Likert scale, as recommended by GRADE working group.[6] During each round, other potential outcomes could also be nominated for consideration.

The following threshold was used to define consensus:

- 70 per cent of participants scoring an outcome of 'critical importance', or less than 15 per cent scoring an outcome of 'limited importance' to determine those deemed to 'critical' outcomes
- The contrary for those deemed to be of 'limited' value
- No consensus for those falling in between

With each round the potential outcomes were refined. Finally a face-to-face meeting comprised of 23 obstetricians, 10 researchers, two neonatologists, two patient representatives and one midwife reviewed the outcome scores and determined those of critical importance, to arrive at the COS. Through this process, the 72 primary and 155 secondary outcomes identified by the systematic review, and 33 outcomes added by clinicians and patients, were refined to 13 core outcomes comprised of four maternal and nine neonatal outcomes.

Maternal outcomes:

- Maternal mortality
- Maternal infection or inflammation
- Pre-labour rupture of membranes
- Harm to mother from intervention

Neonatal:

- Offspring mortality

- Offspring infection
- Gestational age at birth
- Harm to offspring from intervention
- Birth weight
- Early neurodevelopmental morbidity
- Late neurodevelopmental morbidity
- Gastrointestinal morbidity
- Respiratory morbidity

While outcomes have been determined, there is ongoing work to define and determine the instruments to measure these outcomes. Until then, researchers are encouraged to explicitly state how an outcome was actually measured and provide the definition used in each trial. There is encouraging evidence that this work is already having some effect, with 15 planned pessary trials intending to include this COS.

How can I use COS?

For those planning a study, it is worth checking the Core Outcome Measures in Effectiveness Trials (COMET) register at: www.comet-initiative.org/. This provides details about which COS have been registered, their stage of development and associated resources. The Core Outcomes in Women's and Newborn Health (CROWN) initiative website (www.crown-initiative.org/) also has a list of related COS, with resources and contact details if you would like to become involved. CROWN Australasia[7] has been launched to promote COS locally and assist researchers in becoming involved, providing guidance on local resources for those wanting to develop their own COS.

While it is early days, there is a lot to be gained by achieving agreement on what outcomes are important. The inclusion of COS will make the most of the precious research dollar and provide the greatest benefit to patients and the community.

References

1. Williamson PR, Altman DG, Blazeby JM, et al. Developing core outcome sets for clinical trials: issues to consider. *Trials* 2012 Dec;13(1):132.
2. Boers M, Kirwan JR, Wells G, et al. Developing core outcome measurement sets for clinical trials: OMERACT Filter 2.0. *J Clin Epidemiol.* 2014 Jul;67(7):745–53.
3. Duffy JMN, Rolph R, Gale C, et al. Core outcome sets in women's and newborn health: a systematic review. *BJOG* 2017 Apr 19 [cited 2017 Aug 22]; Available from: http://doi.wiley.com/10.1111/1471-0528.14694.
4. Van't Hooft J, Duffy JM, Daly M, et al. A core outcome set for evaluation of interventions to prevent preterm birth. *Obstetrics & Gynecology* 2016 Jan 1;127(1):49-58.
5. Meher S, Alfirevic Z. Choice of primary outcomes in randomised trials and systematic reviews evaluating interventions for preterm birth prevention: a systematic review. *BJOG* 2014 Sep 1;121(10):1188-94.
6. Guyatt GH, Oxman AD, Kunz R, et al. GRADE guidelines: 2. Framing the question and deciding on important outcomes. *Journal of Clinical Epidemiology* 2011 Apr 1;64(4):395-400.
7. Daly JO. Harmonisation of research outcomes for meaningful translation to practice: The role of Core Outcome Sets and the CROWN Initiative. *ANZJOG* 2018 Feb 1;58(1):15-6.

Letters to the Editor

Dr Nick Silberstein
FRACGP, FACRRM, DRANZCOG

The letter of Dr Criton Kasby concerning uterine inversion (*O&G Magazine* Volume 20 No.1 Autumn 2018) contains an important lesson for less-experienced obstetricians.

In a former life, I was a GP obstetrician delivering about 120 babies a year in a small rural centre. The woman I remember had a normal pregnancy and went into labour at term, delivering without problem or assistance. However, she continued to bleed heavily post-delivery. The uterus was palpable, very firm and seemingly very well contracted. Oxytocin did not solve the problem. The only strategy available was a large intravenous line and a rapid ambulance trip to the regional centre 60km away. There, a more experienced GP obstetrician made the correct diagnosis of partial inversion and used the hydrostatic manoeuvre described to solve the problem, no doubt saving the woman's life.

There were many lessons from this experience, which range from the advisability of performing obstetrics in such a small centre (this practice has long since ceased in that particular location), to the diagnosis of the problem, which I had not encountered during my Diploma training, in a subsequent term overseas as a senior house officer, or in more than 1000 GP deliveries. The diagnostic clue seems to be that if the uterus seems unusually well-contracted, there is a problem. This is a message for young players.

Glenda Hare
In response to Dr Michael Simcock's obituary
O&G Magazine Vol. 19 No. 1

Thanks to Dr Michael Simcock, my first child's life was saved. David was born on 14 May 1971 at 9.17am, in Auburn District Hospital. After labouring for many hours, my baby was in a posterior position and in fetal distress. Dr Simcock took quick action. He gave me an epidural, but the fetal distress continued. Emergency action was taken and a caesarean section was performed. My first baby was born healthy and well.

Dr Simcock also cared for me and my second son, Shayne, born on 12 September 1972. He was also born by caesarean section, although born in a more relaxed manner. I am 65 years old now, but I have never forgotten the kind and skilful way Dr Simcock treated me and my babies. If it wasn't for Dr Simcock, I may not have had children and could have lost my own life. I will be forever grateful to Dr Simcock and his wife Barbara.

Dr Amber Moore
FRANZCOG, LLB(Hons), LLM

It was not without irony that I read *O&G Magazine* Volume 19 No.4 Summer 2017, focusing on domestic violence and reflected upon my own recent experience with the media. Many of my colleagues may have seen me interviewed for '7.30' on the ABC in December 2017. I was asked to represent RANZCOG as a general gynaecologist, which I was happy to do. I did research to ensure that I was across the evidence and could reasonably reflect the position of the College, the specialists in family planning and contraception, and the average working O&G. I am, however, also a woman and have ridden the contraception roller coaster myself.

I was extremely disappointed in the approach taken by an otherwise responsible media organisation. Feedback from colleagues and patients have been similar to my own. I was disappointed at the sensationalist portrayal of a mode of contraception that has effectively revolutionised gynaecology. This mode of contraception has allowed women to avoid surgery to manage menorrhagia, allowed women to control their fertility so reliably, allowed women to change their minds with an immediate reversion to their natural fertility and, on top of it all, made it affordable and accessible.

When I was interviewed, I told the truth, based on scientific facts. The program featured the devices Implanon and Mirena. '7.30' outlined their possible side effects – awful, permanent, disfiguring side effects. Reasonably minded women would have dismissed them as a contraceptive they would not touch with a 50-foot barge pole. That makes me feel sad and angry. Why? Because when such devices are portrayed in a negative light, the average woman will believe what they are told and keep away. Yet, what is excluded from their report is the overwhelming weight of international scientific evidence that supports their safety, effectiveness, reliability and cost-effectiveness. Why bother to include that information? Not when you can interview two individual women regarding their anecdotal experiences, an epidemiologist who has a theory about corporate greed, and then share some horrific photos lifted off the net that makes the home audience collectively grimace.

Why am I sad and angry? When irresponsible reporting such as this occurs, it reinforces the oppression of women. It scares women, so they do not have the benefit of making an informed choice. In doing so, it continues to deny women choice; it denies them truth; it keeps them impoverished. It ignores the fact that many women are already impoverished, in violent relationships, in controlling relationships, where the ability to control their own fertility is already compromised. These women end up with unplanned pregnancies. Then they have to choose to either birth or terminate. The decision to terminate is rarely taken lightly. Women are affected

emotionally, even if it the best decision for them. Of course, having a medical or surgical termination has risks and side effects too. For those women who keep the pregnancy, birthing an unplanned baby has life-long effects. It may preclude a woman from going back to work and thus she remains financially dependent. It may place pressure on her relationship. It may affect her relationship with that child, or with the other children in the house. It may put so much pressure on a family that it could increase the stress, resulting in the possibility of domestic violence.

Australian women of my, and my mother's, generation remember the terrible consequences of older style IUDs, like the Dalkon Shield, that were associated with infertility as a result of severe pelvic infections. Class actions against the manufacturers drew a lot of media attention and no doubt those women were never really appropriately compensated for the devastation caused to their lives. This was in the days before IVF, before safe sex campaigns. Now things have changed. IUDs are simply not associated with infection like they used to be, not because the drug company tells us that, but because international evidence tells us. Not research funded by drug companies, but from studies performed by a scale of people from medical students, to junior training gynaecologists, to university medical schools and international scientific institutions.

As a result of these historical disasters, women were warned off having an IUD. As a young woman, and then as a doctor, I have always been very negative about the concept of putting an IUD in a woman who has not yet had children (in the 1990s I would never have had an IUD myself). The 'pill' became the treatment of choice for Australian women. The world-changing miracle that is the oral contraceptive pill put the control of fertility into the hands of women themselves. However, it has NOT seen the unplanned pregnancy rate fall to zero. Why? The reasons unplanned pregnancies occur are many and varied. Reasons include contraceptive failures, poor timing of intercourse because women don't understand their fertile times, or have irregular periods that make it difficult to time when fertility is highest. Sometimes very young women have a kind of fertility denial, such that, they unconsciously tempt fate to see if they can fall pregnant, then have to deal with the issue when they do fall pregnant. Sometimes, however, women are sexually controlled by their partners, who will not wear a condom but will not allow their partner to take the pill. Sometimes women in violent and dysfunctional relationships are raped by their partners. Sometimes these women simply cannot afford to pay the PBS cost of the pill, even if it is subsidised for concession card holders or pensioners.

The most offensive aspect of the whole story is that the portrayal of particular drugs or devices as good or evil does a major disservice to women. The cynic in me sees that it makes a controversial media story and that gets viewers. The conspiracy theories of nasty 'Big Pharma' are an easy way to get an angry emotional reaction. Journalists love to feel like they are making an Erin Brockovich-style exposé. It's harder to accept that we rely on big pharmaceutical companies to research and develop these drugs and devices that can help people. Certainly, the government is not pouring money into research and development of women's health products. The government completely underfunds women's health. The last 20 years has seen postnatal admission times in hospitals more than halve, with no increased outpatient support for new mothers, and it has all gone under the radar. There are no coordinated protests outside maternity hospitals demanding care and justice for mothers. It is interesting that the '7.30' story did not go back to the woman having her Implanon inserted at the beginning of the program and ask her what she thinks about long-acting reversible contraception (LARC). I am sure she adores and has been devoted to the child she birthed when only a teenager, but how would her life have been different if she had not had that unplanned pregnancy?

So what about LARCs. Do not rely on the ABC to give you a 'fact check' on them, because if they did, the story would be different and boring. LARCs work, for most women, not all. You might see stories on the ABC condemning domestic violence. Rightly so. How might the situation change for victims of domestic violence if they could control their fertility and afford contraception that works? What if they could ensure they don't have an unplanned pregnancy that keeps them locked into a cycle of poverty? It is so much easier to condemn something, but far more difficult to discuss the solutions. The ABC chose to do a 20-minute story to scare women, deny them choice, keep them in poverty and oppression, and pretend to be the hero administering 'truth'. Before I was interviewed (being cynical of the media), I asked the reporter, Sophie Scott, what the purpose of the story was, the 'angle'. She seemed a reasonable person, a responsible journalist, a woman and a mother. I asserted that I hoped '7.30' would not act to condemn IUD devices, because they are revolutionary in women's health and can do a lot of good. She told me: 'We are not "A Current Affair"'. Well, Ms Scott, it sure looked like it to me.

Notice of Deceased Fellows

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

Dr Christopher Harison, NZ, 20 February 2018

Dr William Hugh Patterson, 3 May 2018

Obituaries

Dr Ramesh Vasant
(1951–2017)

Ramesh Vasant was born in Durban, South Africa, where he graduated with a Bachelor of Medicine and a Bachelor of Surgery from the University of Natal Medical School. He obtained his postgraduate qualifications in obstetrics and gynaecology from the Royal College of Obstetricians and Gynaecologists (RCOG) in London.

Ramesh returned to South Africa to take up a senior consultant post at King Edward Hospital before entering private practice in Durban. In 1994, he left South Africa for New Zealand, where he worked at Grey Base Hospital in Greymouth for five years and Whakatane Hospital for six years.

Ramesh obtained Fellowship of the New Zealand College of Obstetricians and Gynaecologists in 1997 and, following the amalgamation of the Australian and New Zealand Colleges, was admitted as a Fellow of RANZCOG in 1998.

Ramesh moved to Australia to Frankston Hospital, Victoria, as a consultant. In September 2010, he commenced as a senior staff specialist at the old Gold Coast Hospital. He was involved in the important transition to the new tertiary Gold Coast University Hospital and the further development of the department of obstetrics and gynaecology.

Ramesh was a very passionate and knowledgeable practitioner. His experience and common sense were keenly sought after by colleagues and patients throughout a flourishing career in both private and public practice.

Ramesh enjoyed teaching at both undergraduate and postgraduate level. He maintained a strong interest in current medical literature and was enthusiastic and meticulous in the application of new evidence into his day-to-day practice.

Ramesh continued to show dedication to his work in recent years despite a poor medical prognosis. He was always open and honest about his health, adapting his work life up to two weeks prior to his passing away so that his high standards of service delivery were never compromised.

Never one to complain, Ramesh will be remembered for his humility, ready smile, wisdom and pursuit of clinical excellence, especially in the areas of colposcopy, obstetrics and open gynaecological surgery.

He has mentored generations of obstetric trainees. Ramesh will be sadly missed by our midwifery colleagues. Many women have benefited from and remain thankful for his skills.

Ramesh was very proud that his three children pursued careers in medicine.

A/Prof Deryck Charters
FRANZCOG

Dr Stewart Hastie
(1957–2017)

Stewart Hastie was born in Christchurch, New Zealand. He completed medical training at the University of Canterbury and the University of Otago, graduating with a Bachelor of Medicine and a Bachelor of Surgery in 1980. He embarked on his career in obstetrics and gynaecology at Christchurch Women's Hospital. During his training, he completed diplomas in O&G and child health.

Stewart went to the UK in 1985, initially to the Queen Mother's Hospital in Glasgow, where he obtained Membership of the Royal College of Obstetricians and Gynaecologists (MRCOG). He returned to Christchurch as Tutor Specialist in 1988. In 1989, he was appointed as a specialist at Waikato Hospital, Hamilton. With his colossal energy and drive, Stewart eventually set up a successful private practice in addition to his public work. An early innovator and adaptor, he loved gadgets of all sorts, from computers, cars and phones, to new surgical techniques. He was a keen and well-liked teacher.

Stewart obtained Fellowship of the New Zealand College of Obstetricians and Gynaecologists in 1989. Following the amalgamation of the Australian and New Zealand Colleges, he was admitted as a Fellow of RANZCOG, as well as RCOG, in 1998.

Stewart was key in the evolution of assisted reproductive technology in Waikato's branch of Fertility Associates. IVF initially started at the Anglesea Clinic, then, with the availability of public funding, at Waikato Hospital. Eventually the clinic returned to Anglesea. The clinic grew from 50 cycles per year to more than 400, with a staff of more than 20.

A keen mountaineer and yachtsman, Stewart was South Island International Moth junior champion in 1974. In latter years, he participated in Coast to Coast multisport competitions, crossing the South Island running, kayaking and cycling. A serious water skiing injury prevented his participation in more strenuous activities and his aquatic enthusiasms were confined to model boat building, an interest he had for many years.

With his energy, huge grin, engaging personality and sense of humour, he built a large and successful practice, and was a much admired and respected colleague. He joyfully described himself as 'Hastie by name, hasty by nature', but although quick to make up his mind, his decisions were well-considered and precise.

Stewart's last three years were marred by health issues. He had just stopped his public hospital commitments when he became ill and was admitted to Waikato Hospital, where he died on 15 May 2017. A large funeral was testament to his following among health colleagues and the community.

Stewart is survived by his wife Vicky, children Rebecca, Sarah and Marc, and three grandchildren.

Dr Alastair Haslam
FRANZCOG

College Statements update
March 2018

Revised College Statements

The following revised statements were approved by RANZCOG Council and Board in March 2018:

- **Maternal and perinatal data collection (C-Obs 40)**
  1. Additional links to current national projects to standardise data collection

- **RANZCOG position on reproductive treatment for women of advanced maternal age (C-Obs 52)**
  1. Updated references and strengthening of evidence

- **Female genital mutilation (C-Gyn 1)**
  1. Updated references and links to legislation in Australia and New Zealand

- **Managing the adnexae at the time of hysterectomy (C-Gyn 25)**
  1. Updated references and strengthening of evidence
  2. Additional sentence 'If a salpingectomy has been recommended on the basis of cancer risk reduction, the entire fallopian tube should be removed including any tubal fimbrae adherant to the ovary.'

- **Position statement on robotic-assisted surgery (C-Gyn 29)**
  1. Updated references and strengthening of evidence
  2. Removal of term 'Centres of excellence'

- **Guidelines for visiting surgeons conducting demonstration sessions (C-Gen 6)**
  1. Updated references and strengthening of evidence

- **Guidelines for performing gynaecological endoscopic procedures (C-Trg 2)**
  1. Subtitles on training to align with logbook requirements
  2. Greater emphasis on level 6 due to recommendations from the NZ Health & Disability Commission investigation last year
  3. Greater emphasis on the term 'competency'
  4. Additional section 3 'Credentialing' with sentences in relation to Fellows who have not gone through the AGES training program. 'Credentialing in endoscopic surgery must always proceed on an individual basis, and as such, may proceed outside of this framework, based on individual proof of training, skills and currency.' And, 'Although this statement will help guide institutional credentialing for a new Fellow, it should not be used to restrict scope of practice of any Fellow who is able to demonstrate training in a specific area of practice or procedure,' with links to the College's statement on credentialing (WPI 23)

- **The use of lasers in obstetrics and gynaecology (C-Trg 4)**
  1. Updated references and strengthening of awareness of any jurisdictional obligation in terms of licensing for the use of lasers

College Statements approved with no revisions

- **Guidelines for appointment of O&Gs to specialist positions (WPI 17)**
  No changes

Retired College Statements

- **The use of nifedipine in obstetrics (C-Obs 15)**
  This statement has been retired

- **Standards in maternity care (C-Obs 41)**
  This statement has been retired. Document replaced with new RANZCOG document 'Maternity Care in Australia'

A full list of College Statements can be viewed on the RANZCOG Guidance app or on the website at: www.ranzcog.edu.au/Statements-Guidelines.

RANZCOG Patient Information

There are 33 RANZCOG Patient Information Pamphlets, including the new Pregnancy and Childbirth pack of 18 pamphlets, now available. All of these products can be viewed on the College website.

The following new titles were approved for publication and are now available:

- Heavy menstrual bleeding
- Hysterectomy

Prof Yee Leung
Chair
RANZCOG Women's Health Committee

UGSA ASM

Dr Jenny King
UGSA Chair

Recent times have been difficult for medical professionals working in the field of pelvic floor dysfunction. The Urogynaecological Society of Australasia (UGSA) Annual Scientific Meeting (ASM) was held on 14–18 March 2018, in Adelaide, with the findings of the Senate inquiry into transvaginal mesh looming. However, it was a very positive meeting, focusing on safe, evidence-based practice and the processes of shared decision-making within urogynaecology.

The workshops included techniques of vaginal surgery, complications in urogynaecology, and a cadaver workshop allowing attendees to thoroughly work through retropubic, vaginal and transobturator anatomy. The laparoscopic and robotic workshops covered a wide range of pelvic floor surgery topics, as well as instruction in colposacropexy techniques.

We were fortunate to have five international speakers: Vivian Sung, Halina Zyczynski and Adam Steinberg from the USA, Paul Moran from the UK, and Barry O'Reilly from Ireland. We all face the same challenges in caring for our patients. Accessing the combined experience and wisdom of these five speakers was extremely valuable.

Often, we need a multi-disciplinary approach in the management of patients with pelvic floor symptoms. We were able to call on the expertise of some Australian colleagues: Samantha Pillay and Ashani Couchman for urology; Elizabeth Murphy for colorectal surgery; and Phil Dinning for gastroenterology.

Current controversies around the use of transvaginal mesh were discussed. We held stimulating discussion with representatives from the Therapeutic Goods Association (TGA), experienced general gynaecologists, urogynaecologists and a biomedical ethicist. Discussion concentrated primarily on the processes needed to safeguard patients, without denying them access to innovative treatments. This is an important issue in which UGSA will continue to support the rights of all of our patients.

We hope to see you at the next UGSA ASM, 20–23 March 2019, on the Gold Coast.

Balancing surgical innovation and patient safety. (L to R) Dr Katrina Hutchison, bioethicist; Dr Andrew Pesce, previous AMA President, general O&G; (Dr Tim Greenaway, TGA); (Dr Rupert Sherwood, previous RANZCOG President, general O&G); Dr Anna Rosamilia, urogynaecologist; Dr John Short, UGSA Vice-Chair, urogynaecologist.

RANZCOG 2018

ANNUAL SCIENTIFIC MEETING

Shifting Sands

Exploring the boundaries of specialisation

KEY DATES

Registrations Open	**Now**
Call for Abstracts Closes	**15 May 2018**
Notification to Authors	**14 June 2018**
Deadline for Author Registration	**29 June 2018**
Early Bird Registration Closes	**29 June 2018**
Pre-Meeting Workshops	**15 – 16 September 2018**
RANZCOG 2018 ASM	**16 – 19 September 2018**

KEYNOTE SPEAKERS

Professor Adam Balen
Professor of Reproductive Medicine and Surgery, Leeds

Associate Professor Jennifer E Dietrich
Associate Professor Department of Obstetrics and Gynecology
Associate Professor Department of Pediatrics
Fellowship Director Pediatric and Adolescent Gynecology
Chief of Pediatric and Adolescent Gynecology, Texas Children's Hospital
Division Director Pediatric and Adolescent Gynecology and CME Director
Department of Obstetrics and Gynecology, Baylor College of Medicine

Professor Catherine Nelson-Piercy
Professor of Obstetric Medicine and Consultant Obstetric Physician,
Guy's and St. Thomas' Hospital Trust, Queen Charlotte's and Chelsea Hospital, London

Dr Peter Rosenblatt
Director of Urogynecology, Mount Auburn Hospital, Cambridge, Massachusetts

PRE-MEETING WORKSHOPS

A comprehensive pre-meeting workshop program will be offered including:

Birth Masterclass
Fetal Surveillance Education Program
Introduction to Ultrasound
Obstetric Medical Update
Obstetric Anal Sphincter Injury
Pre-Vocational Obstetrics & Gynaecology Society – A Crash Course in O&G

REGISTER NOW

Take advantage of early bird registration
Register before 29 June 2018 and save up to 20%
www.ranzcogasm.com.au