Amy Coopes reported on the Royal Australian and New Zealand College of Obstetricians and Gynaecologists’ Annual Scientific Meeting, held in Adelaide from 16–19 September, 2018, for the Croakey Conference News Service.

Croakey is a social journalism project for public health based in Australia. http://croakey.org
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Conference preview: women’s health takes centre stage

Amy Coopes writes:

The pelvic mesh controversy, ethical dimensions of genetic screening and IVF, Closing the Gap on maternal and infant mortality and improving health care for sex and gender diverse minorities are some of the issues set to take centre-stage at Australia’s largest conference on women’s health in Adelaide.

A record 900 delegates will attend the Royal Australian and New Zealand College of Obstetricians and Gynaecologists’ Annual Scientific Meeting, bringing together eminent global and Trans-Tasman thinkers to discuss the latest advances and opportunities in women’s sexual and reproductive health.

Themed ‘Shifting Sands’, the 2018 edition aims to showcase the diversity and breadth of the specialty, which ranges from the care of pregnant women and management of issues like sexual dysfunction, pelvic pain and prolapse through to the “hardcore surgeons” of reproductive cancer, from puberty to post-menopause and beyond, according to RANZCOG conference organiser Professor Gus Dekker.

“It’s a very broad specialty, we have people that go from talking very much about psychological reasons for causes of organ dysfunction in women, all the way towards people who are hardcore surgeons and do primarily gynaecologic cancer surgeries,” he said.

Professor Gus Dekker
While an exciting field to work in, Dekker – who specialises in high-risk pregnancies – said the scope of obstetrics and gynaecology also made it a complex landscape to navigate, involving midwives and diploma-qualified GPs through to highly skilled foetal and maternal medicine experts: the so-called “shifting sands” of specialisation.

“This conference is really about exploring those boundaries, where you sometimes have to work together, and sometimes refer, and how changes across the journey of your professional career,” he said.

**Big challenges**

Though maintaining a strong focus on subspecialty research, the 2018 conference aims to meet some of the big challenges for women’s health head-on, with sessions on global maternal health, perinatal mental health, adolescent gynaecology and transgender patient care, and the ethical frontiers of genetic and foetal screening and reproductive technologies.

A plenary on the pelvic mesh scandal recently making Australian and international headlines will also feature in the program, following a **damning Senate inquiry** into the controversial products and series of class actions against the manufacturers (as **reported** earlier this year by Croakey).

“The question now is, how are gynaecologists worldwide going to treat all these women who have the mesh?” said Dekker. “We will hear some interesting, controversial presentations on this issue.”

For the first time, RANZCOG will hold its annual **Aboriginal and Torres Strait Islander Women’s Health Meeting (ATSIWHM)** in conjunction with the ASM, with a mix of technical skills training targeting Aboriginal health workers and workshops for clinicians working in Indigenous communities. There will be sessions on: cultural safety; birthing on country; Ngangkari traditional healers; smoking, diabetes, domestic violence and mental health in pregnancy; premature births; and sexually transmitted infections and screening.

Meriam woman and director of Melbourne University’s Indigenous Health Equity Unit, **Professor Kerry Arabena**, will deliver the ATSIWHM keynote address on the **First 1000 Days Australia** project – a multigenerational, pre-birth, interventions-based cohort study of Aboriginal and Torres Strait Islander families, of which she is lead investigator.

Darwin-based obstetrician and gynaecologist and Yadhiagana woman **Kiarna Brown** will present during the ASM opening plenary on the government’s Closing the Gap strategy and the vital role individual clinicians and the College can play.

“We’ve really tried to have a broad focus on women’s health, looking at the psychosocial context in Australia and beyond,” said Dekker.

**Some home truths**

Looking inward, the program also hopes to confront some home truths for the specialty, with presentations on burnout and doctors’ mental health from **#MH4Docs** advocate **Geoff Toogood**, a session on mandatory reporting to AHPRA, and a talk from former AMA president **Michael Gannon** on the changing landscape of medical training and challenges of safe hours, work-life balance and technological disruption.

Gender equity is a pressing issue for the College, with 83 percent of trainees now female but men continuing to outrank women in Fellowship positions 52 percent to 48 percent.
Hobart-based obstetrician and gynaecologist Kirsten Connan recently completed a Masters research thesis into gender and leadership within the specialty, examining trends at 98 RANZCOG-affiliated hospitals in Australia and New Zealand and 20 O&G university departments across the two countries. She also surveyed the College membership on the issue, drawing an overwhelming response. Connan will present her findings at the ASM.

“It’s not unique to O&G, and it’s not unique to O&G in Australia and New Zealand, but there’s no doubt that, as we see in almost every other area across organisations and across workforces, women desire leadership,” said Connan. “It’s no less than men, in fact it’s often more than men, and yet women are the ones who can’t achieve or sustain high levels of leadership.”

Driving debate

A passionate advocate for the introduction of quotas, Connan said the medical profession had been slow to recognise the importance of this issue, and given RANZCOG’s unique place in the advocacy of women’s rights and wellbeing, it ought to be driving the debate.

“I think as a women’s health care College we should be leading the way, not following other specialty Colleges in relation to the discussion on gender and leadership,” she said. “And to do that we need to not just talk the talk, but to implement some really practical solutions as to how we can move our College forward to be not just a voice on leadership and gender, but also demonstrate the value of having women in leadership and what that means.”

It wasn’t just women who wanted change, she added, describing a “different kind of cultural era” for trainees where – regardless of gender – people were looking for greater balance between their professional and personal lives.

This was also reflected in a growing social consciousness and desire for the College to look beyond its own agenda, said Connan.

“One of the most exciting things about this conference is it’s looking with such a broad perspective at lots of things that I think many institutions are trying to capture, about the impact of social awareness,” she said.
Women's health took centre stage at RANZCOG18 conference

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

A/Prof (mary) Louise Hull @MLouiseHull · Aug 26
Lots of great speakers will be in Adelaide at RANZCOG annual meeting in September ranzcoh18

RANZCOG - O&G @ranzcoh
Associate Professor Jennifer E. Dietrich @jdietri is President of the North American Society of Paediatric and Adolescent Gynaecology. Come hear her speak about the evolving landscape of paediatric gynaecology at the...

RANZCOG - O&G @ranzcoh · Aug 31
Are you coming to the #ranzcoh18 ASM? The Meeting Dinner will have you dancing the night away at the Adelaide Oval. Don't miss out on the fun, register now!

Enrich your career and make connections that matter at the RANZCOG 2018 ASM

See you in Adelaide!

Sunday 16 – Wednesday 19 September
Adelaide Convention Centre
Lessons and questions for women’s health specialists following pelvic mesh storm

When a Senate inquiry’s report into transvaginal mesh implants was released earlier this year, it privileged the voices of women who had been adversely affected. The overall picture from the inquiry showed “the medical profession in a very poor light”, the Senators reported.

At the Royal Australian and New Zealand College of Obstetricians and Gynaecologists’ Annual Scientific Meeting, gynaecologists highlighted the damaging impacts of this medical history on the profession itself, as well as upon regulatory authorities. One prominent specialist described his practice being bombarded with phone calls accusing him of being a “butcher”.

Image from tweet by Amy Coopes: Hearing from @DrSteveRobson on the damage of the mesh controversy to the profession
Amy Coopes writes:

Leading Australian and international gynaecologists have shared their devastation and frustration at the political and regulatory controversy engulfing the profession over the use of synthetic pelvic mesh.

The implants, used to treat urinary incontinence and prolapse in an estimated 140,000 Australian women over the past 20 years, were banned nationally by the Therapeutic Goods Administration in 2017 amid mounting reports of painful, debilitating complications and a series of class actions and inquiries worldwide.

Hundreds of Australian women came forward to a Senate inquiry to share their stories of pain, distress, loss of function, isolation and humiliation from adverse effects ranging from tissue erosion and infection to bleeding and incontinence.

The Senate report, published in April, makes for harrowing reading, and reserves some of its harshest criticism for the “dismissive and disrespectful” treatment meted out by doctors when these women sought to have their concerns addressed.

The report highlighted a complex regulatory and oversight landscape in which the specialist colleges, while responsible for training doctors and maintaining best practice guidelines on clinical conditions, have no role in actually credentialing medical professionals or in device regulation.

Dismay and frustration

Members of the Royal Australian and New Zealand College of Gynaecologists and Obstetricians – the specialist body overseeing women's health doctors across the two countries – vented their dismay and frustration at the controversy at their annual summit in Adelaide.

In a session dedicated to pelvic surgery and the use of mesh implants, College President Dr Steve Robson reflected on the immense impact of the events on the profession, destabilising public trust in not only gynaecologists but doctors more generally, and eroding confidence in the TGA.

“There was a huge sense in the community that you couldn’t trust O&G specialists or doctors in general, doctors felt they couldn’t trust the regulators, nobody felt that they could trust lawyers, and there was a sense of unease that nobody knew who they could turn to, who they could rely on,” Robson said in an interview following the session.

An emotional Robson told colleagues he had not been prepared for the vitriol that followed his public apology to affected women, with hundreds of people contacting him personally and bombardng his practice with phone calls accusing him of being a “butcher” and running an “abattoir”. There was an “extraordinary” atmosphere of hostility and high emotions, with media reports drawing comparisons to the thalidomide birth defects scandal.

“When you’re in a caring profession your whole ethos is about wanting to help. It’s like a stake through your heart because it gets right at the core of who you are and what you want to do,” he said.

Thorough investigation required

Demand for the surgery had plummeted by about 30 percent due to the publicity, and Brisbane-based urogynaecologist Dr Alex Mowat said it had been a difficult time for trainees, with uncertainty over surgical approaches and inferences of poor training and incompetence from the public.
Dr Anna Rosamilia from Monash University presented on management of the most common complications from mesh surgery, of which she said pain was the most intractable.

Rosamilia noted that, while it was an “understandable reaction” in the present media climate around mesh to blame it for any pelvic pain, it was important to thoroughly investigate for all potential causes.
Pain is the most difficult thing to treat in this setting, says Rosamilia. It’s an understandable reaction in this media environment for women to blame any pain on the sling, but it’s important to get to the bottom of what is causing it. #RANZCOG18

ACOG and AUGS Committee Opinion Mesh and Graft Complications in Gynecologic Surgery (2017)

- Ideal timing - favors earlier intervention
- Extensive dissection & collaboration with plastics, colorectal, urology, pain management
- Outcomes of mesh revision surgery variable

Short-term series describe positive functional outcomes
Recurrence prolapse or urinary incontinence in up to 1/3rd
111 women with & w/out surgery >2 years, 30% same/worse
Up to 50% persistent pain/dyspareunia after revision

Who benefits from removal of only vaginal component or total removal including groin dissection?
Rosamilia told colleagues that, while there was “no doubt” that mesh caused complications, the weight of evidence and professional opinion continued to support its use.

“I don’t think we are lost in the wilderness,” said Rosamilia. “Women feel that they have been done a disservice and I don’t think we have managed our complications well, but we are not lost in the wilderness, we just need to phone a friend.”

This was echoed by Boston urogynaecologist Dr Peter Rosenblatt, who said mesh remained the go-to for many surgeons in the United States and was still considered the gold standard for recurrent or significant prolapse.

“I hope what you have here in Australia is a moratorium not a ban,” said Rosenblatt, describing some of the local reporting he had seen as “salacious”.

Ditching the use of mesh in favour of a return to the older ways of doing things was “a devolution not and evolution and we shouldn’t be going there,” he added, warning that overzealous regulation of the medical device industry risked stifling innovation.

Adelaide-based pelvic floor specialist Dr Ian Tucker shared the example of coronary angiography, which is now the cornerstone of non-invasive cardiology. When the procedure was first rolled out, he said, 50 percent of people died on the table. Had the response been to ban the treatment, the entire field would not have advanced.

**Lessons and conundrums**

Robson said the controversy had offered some important lessons for the College, and posed some conundrums (see this Twitter thread).

It had highlighted how essential it was to do everything in partnership with rather than at professional remove from the women it served, and illustrated that – once lost – public confidence was very difficult to rebuild.
“I think the biggest question for us is how do you possibly get the balance right, where people have enough faith in what you, in your attempts to help them,” said Robson.

“And how do you maintain their trust, (so that) people at all times understand that you’re putting them first – not your reputation or your own self-interest – that you are trying to help women and make their lives better.”

For the College, it posed some fundamental questions about their core business and priorities, he added.

“Where do we sit, how far do we go do we intrude on something so fundamental as the doctor patient relationship? When they are taking a patient through a consent for an operation do we specify precisely what it is they have to say?”

“In our public dealings do we advocate for victims, do we advocate for Fellows (of the College) to try and protect them better, is it even possible to strike a balance between those things?”

**Tweets from Dr Steve Robson’s presentation**
You can track Croakey's coverage of the conference here.

Lessons and questions for women's health specialists following pelvic mesh storm

Lessons from the mesh journey, from @DrSteveRobson. Totally sucked the oxygen out of the College's social justice agenda, tarred all their activities with the same brush #RANZCOG18

- When the community — including its elected representatives — are given a sense of 'failure' by the profession, it is extremely difficult to rebuild authority and reputation.
- Our profession must not accept uncritically the assessments and processes of others — for example, the TGA.
- Our profession must involve the community — the women we serve — in our activities as much as possible.

Being told you have a problem with women is the worst thing you could say to an O&G says @drsteverobson
A mock trial

The whole meeting had a chance to consider the issues with a mock trial in the main auditorium on a case involving the use of a mid-urethral sling, resulting in PTSD and inability to work.

Doctors were asked to cast their votes on the way the case was handled, illustrating divergent opinions on issues with paperwork, supervision, and operating experience.
You can track Croakey's coverage of the conference here.

Lessons and questions for women's health specialists following pelvic mesh storm

Court Case at #RANZCOG18
How do we empower relatively junior consultants/Registrars to request senior help across specialties? Flat hierarchy #RANZCOG18

I love Dr VERY Senior Kidney #RANZCOG18

Watch the interview

Steve Robson at #RANZCOG18
Powerful calls for health system to improve care to trans and gender diverse patients

The Mercy Hospital for Women in Melbourne has made a concerted whole-of-hospital effort to improve the care provided to trans and gender (TGD) diverse patients.

This has included a staff-wide education program, including for those in food services, telephonists, clerical staff and orderlies, delegates were told at the Royal Australian and New Zealand College of Obstetricians and Gynaecologists’ Annual Scientific Meeting in Adelaide.

This program focused on skills such as active listening and a non-judgmental approach, and on respectful inquiry about people’s preferred pronouns and name, and language.

Amy Coopes writes:

Sexual and reproductive health specialists have been urged to see through the political and media rhetoric around transgender Australians, and instead focus on providing compassionate and competent care for the patient in front of them.

Paediatric gynaecologist Dr Charlotte Elder, from Melbourne’s Mercy Hospital for Women, delivered a succinct and powerful 101 on how to deliver affirming care to trans and gender (TGD) diverse patients, who are among the country’s most vulnerable populations.
With Prime Minister Scott Morrison recently resurrecting a damaging tabloid debate around TGD children invoked by opponents during last year’s marriage equality vote, Elder said it was important for doctors to be armed with the facts and empowered to treat these patients in a way that allowed them to realise their full potential.

“The main thing is that doctors are informed, and gynaecologists are able to see through the politics and see the person in front of them, and give them the best evidence-based care,” Elder said in an interview following a session designed to empower doctors as advocates.

“Certainly there has been a lot of conversations in the media about transgender issues and transgender people, but I think it’s really important as doctors to separate ourselves from the politics and care for patients,” she said.

**Vital to improve care**

Elder sought to dispel myths and to impress upon colleague why it was so vital to get this right, with a sobering one in three TGD young people in Australia attempting suicide and worse outcome across a range of indicators in physical and mental health and wellbeing.

Critically, these outcomes were not inherent to being trans but the result of discrimination, stigma, social exclusion, bullying, rejection by those closest to them and lack of access to timely, personalised care, she said.

In an interview following the session, Elder said:

> **We know that transgender people have worse outcomes across physical, mental and emotional wellbeing, and that trans-affirming healthcare will help those outcomes.**

> **We also know that there’s no evidence of long-term harm from trans-affirming healthcare.**

> **And looking at health outcomes in trans people who are denied access to care, their health outcomes are uniformly lower than other Australians and it’s not fair, they need to have the same opportunities as everyone else.**

Data presented at last year’s LBQ Women’s Health Conference in Sydney showed that almost one in three TGD people have been subjected to harassment in medical settings and one in five had been refused care due to their gender status. More than half were only out to some of a few of their medical providers (33 percent) or had disclosed their gender status to none of their health team (21 percent).

That conference heard that services not known to be accessible were assumed to be inaccessible by TGD populations, and it was important to loudly and proudly declare that clinical spaces were safe, competent and affirming.

Speaking to a room full of obstetricians and gynaecologists, Elder said everyone would be familiar with the concept of sex assigned at, or these days, often well before birth via genetic testing or imaging of the foetus.

For someone who was TGD, she explained, their experienced or affirmed gender did not align with this label. Some patients identified with another gender, be it transmasculine or transfeminine, while others had an affinity with neither and identified as non-binary.

Like homosexuality, being TGD was not a mental disorder and was independent of a person’s sexuality, Elder told colleagues. It was often, but not always, associated with dysphoria, or distress. She emphasised that being trans was not a “choice” but simply who someone was.
Emphasis on respectful interactions

Gender-affirming health care sought to meet the patient wherever they were on their journey, with an emphasis on respectful interactions and not making assumptions, said Elder.

Care differed from person to person, but could include psychological and social support, use of hormones, surgery, assisted reproductive technologies, physio and speech therapy. It also encompassed domains of social and legal recognition, she added.

“It’s different for everyone and everyone’s journey is different, however having the access to it is what’s important,” said Elder. “Essentially, it’s allowing someone to access care which will let them live their lives to the full.”

At the Mercy, delivery of affirming care had required a whole-of-hospital approach to improving service delivery, starting with a Grand Rounds on Trans 101 and extending to a staffwide education program of personnel right down to food services, telephonists, clerical staff and orderlies.

This program focused on skills such as active listening and a non-judgemental approach, and on respectful inquiry about people’s preferred pronouns and name, language around body parts and using generic terminology for anatomy, and refraining from gendered remarks around the experiences of ‘women’ and ‘men’. The hospital had also looked at the imagery on display in public areas to ensure it was inclusive.

“(The aim is) that people have the skills for interacting with transgender people and not feeling like they’re floundering and not leaving the transgender people feeling judged or like they got inadequate care,” said Elder.

Elder took colleagues through some of the important clinical elements to be aware of in TGD populations, including bleeding on testosterone, endometriosis and pelvic pain and cervical screening for transmasculine patients.

She also discussed some of the surgical complications from feminising genitoplasty for transfeminine patients, compounded by the fact that these procedures were often performed offshore without adequate followup, and that these patients were doing long-distance air travel on oestrogen supplementation, placing them at risk of DVT and blood clots in the lung. It was also important to screen both populations for breast cancer and sexually transmitted infections.

“My role here today was really to empower individual doctors to care for the person in front of them and through spreading that awareness allow individual advocacy to flourish,” she said.

The session was welcomed by delegates to the annual scientific meeting of the Royal Australian College of Obstetricians and Gynaecologists, the peak Trans-Tasman meeting of women’s health specialists, with many doctors applauding the College for giving the issue prominence on the summit’s agenda.

Specialists were also updated on the legislative landscape relating to treatment of TGD minors, following last year’s Family Court ruling on hormone access.
You can track Croakey's coverage of the conference here.

On the treatment of gender dysphoria & evolution of involvement of the Family Court #RANZCOG18

Re Alex (2004)

- Gender dysphoria (F to M). Applied to family law court to receive hormonal therapy in transitioning
- Judge used Marion’s case as precedent and ruled that as this was ‘special medical treatment’ the family law court (not parents/guardians) are authorised to make this decision
- no adolescent was capable of making decision on their own behalf
- treatment was delayed but finally granted
- later Alex applied for double mastectomy through the family law courts

Re Jamie (2013)

- Due to increasing applications through the family law courts
- ruling that puberty blockers could be commenced if there was agreement between child and parents as well as medical staff

Re Kevin (2017)

- Ruling which removed the court’s involvement in the hormone replacement therapy process for children where both the family and medical staff agreed.
- The case, known as Re Kelvin, was brought by a father of a 15 year old transgender child, who asked the court to consider whether previous case law requiring the court process for unopposed applications should be overturned.
Safe schools

There were some pointed remarks about political rhetoric during the day’s talks, with several speakers at an earlier panel on adolescent sexual health deeply critical of the abolition of the Safe Schools program and the recent “gender whisperer” commentary from the Prime Minister.

Mental health matters

Dr Tonia Mezzini, an Adelaide-based sexual health physician with a particular interest in transgender mental health, said the axing of Safe Schools was a “terrible failure to acknowledge that a lot of mental health issues for young people are around sexuality & gender diversity” at a time when growing numbers of adolescents were presenting in distress to the nation’s EDs.

The American Academy of Pediatrics has released a comprehensive policy statement on the care of TGD children and adolescents, confirming that gender-affirming care improves outcomes and debunking the “desistance’ myth that the majority of children grow out of their gender identity questions.

“Research substantiates that children who are prepubertal and assert an identity of TGD know their gender as clearly and as consistently as their developmentally equivalent peers who identify as cisgender and benefit from the same level of social acceptance,” the statement reads.

Melbourne’s Royal Children’s Hospital, a leading authority on TGD patient care, recently published new standards of care and treatment guidelines for doctors, and the Royal Australasian College of Physicians – home to the national’s paediatric doctors – has also been active lobbying in this space.

In Australia, Elder said ANZPATH – the Australian and New Zealand Professional Association for Transgender Health – were powerful advocates for change, and there was also scope for specialist colleges like RANZCOG to play a more active role.
Tweet reports

#ranzcg18 @WePublicHealth

Hearing from Charlotte Elder from @MercyHealthAus on transgender health care #RANZCOG18. Elder says the Mercy is proud of its pastoral care and social justice agenda

Trans* 101

affirmed gender is not consistent with gender assigned at birth

- not a mental illness
- can be associated with dysphoria (distress)
- independent of sexuality
- may be trans-male, trans-female or non-binary
- around 1% of the population depending on how you ask the question

#ranzcg18 @WePublicHealth · 22h

The most important thing is the concept of ‘choice’. It’s not a choice, if it was a choice why the hell would you choose it, it’s really tough, says Elder. Trans is what you are, it’s not a choice #RANZCOG18

#ranzcg18 @WePublicHealth · 22h

Why does it matter? And what is gender-affirming health care. Elder says 1 in 3 trans people will attempt suicide, staggering statistic #RANZCOG18
You can track Croakey's coverage of the conference here.

Powerful calls for health system to improve care to trans and gender diverse patients

Watch interview with Dr Charlotte Elder

#RANZCOG18
Calls for gender reform at male-led women’s health specialty college

If the full contribution of women to economies and societies isn’t realised, it’s not only women who won’t reach their full potential - whole countries won’t reach their full potential.

Helen Clarke - former New Zealand Prime Minister

Dr Kirsten Connan: calling for action on the gender power gap

Amy Coopes writes:

The Royal Australian and Zealand College of Obstetricians and Gynaecologists (RANZCOG) has been urged to take action to tackle male dominance in leadership positions in a specialty dedicated to women’s health.

Research presented at the RANZCOG annual scientific meeting in Adelaide showed that men are over-represented in leadership positions within the College and the discipline more broadly, despite women being 63 percent of College members and 83 percent of trainees.

Hobart-based obstetrician Dr Kirsten Connan, presenting the findings of her Masters in Clinical Education research, issued an impassioned call to arms for the RANZCOG to confront a startling gender gap in positions of power.

Affirmative action, including quotas for women in leadership positions, was needed, she said.
Since the College’s inception, only one of 10 past presidents had been female, one of seven board members was female and nine of 29 seats on the Federal Council were occupied by women – the latter number remaining unchanged in a decade. This was despite College membership being 63 percent female and women trainees outstripping men for more than two decades, now by a significant margin.

Women occupied little more than a third of institutional leadership positions within the discipline, including university and hospital heads of department, with the notable exception of New Zealand’s North Island and Auckland City Hospital (100 percent female-led) and Westmead Hospital in Sydney (80 percent).

The only areas where women outnumbered men in O&G leadership were in the so-called ‘softer’ area of education — 71 percent of the College’s training and assessment state chairs and 53 percent of integrated training program leads were females, said Connan.

“We have an issue in gender and leadership,” Connan told delegates. “We are not alone when it comes to the leadership gender gap, but we are all very much alone when it comes to solutions. RANZCOG, now is our time to lead.”

**Implicit and explicit discrimination**

Connan discussed what she described as the “leaky pipeline” which had allowed this problem to take root, with the sheer numbers of new female trainees offering a false sense of security that the problem was on its way to being solved.

But the pipeline was far from sound, with workplace cultures implicitly and explicitly discriminating against women. The so-called “motherhood penalty” for women leaving the workforce to have children saw people lost from the system.

As part of her research, Connan surveyed the entire College membership for their views on gender barriers and solutions. Respondents commonly cited time and financial pressures as a disincentive to seek leadership, and these were more pronounced for women, who said they also had to fight the assumption that they were less capable or committed due to competing family demands.

Others described an “old boys club” network where ascendancy was predetermined: a conservative hierarchy dominated by male private practitioners that was not representative of the broader College membership.

Women who were chosen for leadership roles were often those perceived as non-threatening and unlikely to advocate on behalf of the majority, another respondent remarked, while still others called for shorter leadership terms and faster turnovers to keep the College dynamic and give more people opportunities.

**Striking themes**

One of the most striking themes was how gender affected perceptions of ability, and how ‘male’ qualities – strength, decisiveness – were equated with good leadership. Women were seen as less credible because they were more willing to compromise, and these assumption was internalised by women themselves, making them less likely to nominate for leadership positions, Connan said.

RANZCOG is not alone among trans-Tasman specialist medical colleges confronting gender disparities – it was a prominent issue at last year’s annual meeting of Australian and New Zealand emergency doctors.
But as a specialty focused on women, with the most heavily female trainee cohort of any discipline across the two countries, Connan said the College was in a “unique position”.

If RANZCOG simply relied on the pipeline – the status quo – to offer solutions, Connan said gender equity at Federal Council level remained at least a decade away, and much longer for more senior positions.

**Affirmative action required**

Affirmative action, including quotas for women in leadership positions, was what was required for meaningful change. In an interview following the session, Connan said:

- “I believe now’s the time for RANZCOG to embrace quotas.
- It’s not the only tool, but it’s a really well-proven effective tool that works really quickly, and I think that’s the challenge that we need to embrace.
- We can keep having the conversation, but eventually we have to put some really practical pragmatic steps in place, and quotas would be one of those.”

Connan urged the College to adopt a 35 percent quota for women on Federal Council, complemented by a 35 percent quota for males in the trainee intake to ensure that, over the long term, there was a balance.

She also called for RANZCOG to draft a gender equity action plan, including targets and timelines, and to formalise mentoring for women interested in leadership roles.

Without buy-in and involvement of both men and women at every level of the College, Connan said O&G risked becoming a “second tier specialty” too easily dismissed as a special interest group for 50 percent of the population.

“We need both males and females equally invested into women’s health care,” she said. “We will miss out economically, we will miss out in terms of legislation around women’s and children’s health care, if we don’t have both men and women engaged in that process.”

Among respondents to Connan’s survey, representing one-third of the College membership, there was a definitive opposition to quotas, with the strongest resistance coming from male specialists and, interestingly, female trainees.

Overwhelmingly, responses to the question urged that appointments be made on the basis of merit, but Connan said this failed to consider that what merit looked like was in fact a very gendered concept.

She cited data showing that when paper authorship was blinded in journals, it resulted in greater gender and ethnic diversity, and the use of blind auditions to address gender bias in orchestras, illustrating that merit could have an implicitly gendered dimension. She said:

- “It’s a conversation that we’re hearing all the time that people tend to hold in opposition quotas and merit but actually we know that meritocracy is a really difficult thing to define, for most of us it actually comes from the background of privilege as opposed to true merit.
- I think if you unpack some of the cultural considerations behind what merit is, actually you will find that in O&G actually pretty much everyone has equal merit in terms of being supported through the process of leadership learning.”
Seize the day

Among respondents to Connan’s survey, female specialists were significantly more likely to want a future leadership position than their male counterparts and to report barriers to these plans.

Half of all those surveyed – overwhelmingly Fellows from Australia aged 30-60, 58 percent of whom were women – reported experiencing gender bias and, again, this was more prevalent among female specialists and trainees than their opposite number, as well as being more common among trainees overall than senior colleagues.

Respondents to Connan’s survey also had some suggested solutions, including job-sharing of leadership roles, decentralisation and the ability to teleconference into meetings, stipends to cover travel and childcare, female sponsor networks and a concerted campaign to increase female participation.

For women in the College, she had a very simple message: seize the day. Instead of waiting to be more experienced, more qualified, more perfect, it was time to banish the impostor syndrome and take the first steps into leadership.

And for the College itself, Connan said it was time for an “awakening”, describing equity as a social justice issue.

“The issues around gender bias, both implicit and explicit, and gender barriers have been there for a long time, and I think as a community we are now working towards having the conversation. I felt that it was time within RANZCOG to have that conversation as well,” she said.
tweet reports

#ranzcg18 @WePublicHealth · 22h
We'll now be hearing from @connankf on gender equity in O&G leadership
#RANZCOG18

#ranzcg18 @WePublicHealth · 22h
Hearing all-too-familiar stories from @connankf on encounters with sexism in medicine - presumed to be a secretary, an assistant, told skirt suits must be worn by women to College exams #RANZCOG18

#ranzcg18 @WePublicHealth · 22h
"Gender bias exists everywhere and we all hold them - I am no exception". Applause from the audience as @connankf commends #RANZCOG18 for - for the first time - providing a creche, and for the diversity of speakers.

#ranzcg18 @WePublicHealth · 22h
We have an issue in gender and leaders says @Connankf #RANZCOG18

#ranzcg18 @WePublicHealth · 22h
One female president out of 9 total at @ranzcg over the years. Board leadership 14% female. Last year 80% of trainees were women - this is a glimpse of the future of our specialty #RANZCOG18

#ranzcg18 @WePublicHealth · 22h
In Australia, Westmead Hospital has 80% female leadership, while Auckland City Hospital & North Island of New Zealand are 100% female-led #RANZCOG18

#ranzcg18 @WePublicHealth · 22h
Australia & NZ findings mirror picture in the US. @connankf talking about the 'leaky pipeline' of leadership - workforce cultures, motherhood penalties that disadvantage women advancing to the top #RANZCOG18

#ranzcg18 @WePublicHealth · 22h
"We are not alone when it comes to the leadership gender gap, but we are all very much alone when it comes to solutions. @ranzcg, now is our time to lead." - @connankf #RANZCOG18

Calls for gender reform at male-led women’s health specialty college #RANZCOG18

You can track Croakey's coverage of the conference here.
Calls for gender reform at male-led women’s health specialty college

#RANZCOG18

Croakey
“Conference News Service”
You can track Croakey's coverage of the conference here.

Calls for gender reform at male-led women's health specialty college

#RANZCOG18

#RANZCOG18
Calls for gender reform at male-led women's health specialty college

#RANZCOG18

Croakey

Conference News Service
Warm reaction

Dr Hilary Joyce FRANZCOG  
@dhilary_joyce

Brilliant. Yes @Connankf an awakening in Gender equity and Leadership @ranzcog #ranzcog18 Thanks also @coopesdetat

#ranzcog18 @WePublicHealth  
Thanks to @connankf for sitting down to chat gender equity & leadership at @ranzcog following a thought-provoking plenary session at #RANZCOG18 youtu.be /iTC73S4cA

Andreas Obermair  
@AndreasObermair

62% of @ranzcog is female but only 1 female president in the last 20 years. Fabulous analysis by Dr K Connan #ranzcog18

Inspectorcharlie  
@inspectorcharl2

We’re finally addressing gender diversity and leadership in our college! Such a great talk @Connankf @RGrivell #ranzcog18
You can track Croakey’s coverage of the conference here.

Calls for gender reform at male-led women’s health specialty college

#RANZCOG18
You can track Croakey’s coverage of the conference here.

Calls for gender reform at male-led women’s health specialty college

#RANZCOG18

Nisha Khot
@Nishaobgyn

Women in @ranzcg in the last decade. The next decade has to look different #genderequity a priority for @ranzcg as it is for auspol @Connankf #RANZCOG18

![Graph showing women in RANZCOG]

Nisha Khot
@Nishaobgyn

An absolutely brilliant presentation by @Connankf addressing gender equity in @ranzcg leadership #RANZCOG18 The time is now. We owe it to future generations to address #genderequity in this decade, not the next.

Steve Robson
@DrSteveRobson

Outstanding talk from @Connankf at #RANZCOG18 with important views and data on #genderequity in College leadership. Impossible not to agree. @ranzcg

![Photo of speaker at conference]

#RANZCOG18

Croakey
“Conference News Service”
Amy Coopes writes:

Sexting, labiaplasty and sex education in schools took centre stage at a popular session on adolescent health for Australian and New Zealand obstetricians and gynaecologists at their recent annual scientific meeting in Adelaide.

Titled “The Novice Adventurer”, the plenary session took delegates to the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) conference through the tips and traps of treating young patients, traversing a complex legal, ethical and sociological landscape.

International guest speakers Professor Adam Balen (UK) and Professor Jennifer Dietrich (USA) offered an update on the management on some of the common and more complex conditions seen in the burgeoning field of paediatric and adolescent gynaecology (PAG).
Dietrich, a Professor of Paediatrics at Baylor College of Medicine and immediate past president of NASPAG, the international peak organisation for PAG specialists, said patients could present with anything from disorders of puberty and menstruation through to contraception and STI screening, cancer, trauma, and congenital abnormalities of the reproductive tract.

The field had “exploded” in the past decade, she said, with a growing body of evidence supporting better outcomes for paediatric specialists, and a demonstrated need for their services: “intimate, personal care delivered in an age-appropriate fashion” where communication was key.

“If you open the doors, they will come,” Dietrich told delegates. “These people are out there and they need our help.”

**Issues facing teenage girls**

Setting the scene for her talk, Dietrich, who works at the Texas Children’s Hospital, shared some of the facts on teenage girls in the US. One in four would experience sexual assault, 22 percent were already sexting, and there were almost 20 million new cases of STIs among 15-24 year olds in the United States every year, with half of all adolescents sexually active by the age of 17.

The average age a young girl would become the victim of sex trafficking was just 12-14 years old, Dietrich said, and bullying was all too common, whether at school (20 percent) or online (16 percent). More than one third (36 percent) of girls in the later years of secondary school were using cannabis, 1 in 5 (22 percent) were drinking alcohol and 14 percent were smoking tobacco.

Dietrich’s talk sparked some consternation on social media after she shared American College of Obstetricians and Gynaecologists (ACOG) guidance recommending teenage girls pay their first visit to a gynaecologist between the ages of 13 and 15.

As indicated in the tweets below, primary care and generalist doctors argued such advice had no place in Australia, where most adolescents could be capably cared for by their GP.
You can track Croakey’s coverage of the conference here.

On sexting, sex education and other health issues for children and young people

Croakey

“Conference News Service”
On sexting, sex education and other health issues for children and young people. #RANZCOG18

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

Amanda Brownlow @On_the_Downlow

In the USA, maybe. Here at home where we are fortunate to have a robust primary care sector, we should be encouraging young women to establish a relationship with a GP they trust: for age-and-stage appropriate, whole-patient care. #yourGP

Gillian Riley @Medical_history

Respectfully to my Ranzcog colleagues. This is not your role. You are not trained or best placed to deal with this and comments like this are disrespectful to primary care. #justagp

RANZCOG - O&G @ranzcoog

#ranzco18 @acog recommends that the first visit to a gynecologist be done between 13 and 15 years of age. @jedleiti

Thinus van Rensburg @tvren · Sep 18

Curious to know if this advice is supported by @ranzcoog? In our city we barely have enough Gynae resources as it is and it is very hard to think of any service a Gynae would offer these girls that a 1/2 competent #justagp could not

RANZCOG - O&G @ranzcoog · Sep 18

This is a reference to the US model and recommendations

Michael Rice @M_C_Rice · Sep 18

Warrants @ranzcoog response then, in Aus context, applicable to our geography, workforce and patient needs

susan bewley @susan_bewley · Sep 18

Replying to @ranzcoog @fedupobstetricf and 2 others

Er... and what is the evidence that visiting a gynaecologist is going to help? Please advise

#RANZCOG18
Australian context

Dr Rebecca Deans, from the University of New South Wales, shared some Australian data showing that 8.8 percent of adolescents had sent a nude image, with this rate reaching 20 percent among 18-year-olds. Among 11-15 year olds, 15 percent said they had seen or received a sexual image.

Navigating the legal landscape around consent, sex and social media was a potential minefield, not only for the teenagers involved but also their treating doctors, said Deans, taking delegates through a legislative 101 on treating minors, assessing competence, and when to report concerns.

Adolescence was a time of negotiating newfound autonomy and nascent desire, said Deans, describing the difficulty of striking a balance between “criminalising exploration and protecting (minors) from exploitation”.

She impressed on delegates that every discussion with an adolescent patient on contraception should involve an assessment of any potential illegality (age of consent, abuse, non-consensual acts), a pregnancy test and STI screen, and a comprehensive discussion of the risks, benefits and adverse effects of their chosen method, alternatives, as well as education on proper use.

Consideration should be given to the HPV vaccine, and safe sex and avoidance of sexually transmitted infections discussed, added Deans.

How not to alienate young people

Sexual health physician Tonia Mezzini stole the show with a role play on the Dos and Don’ts of seeing a teenage patient. The take home message was “You’re not cool. Deal with it”.

“One of the things that I think people make the mistake in assuming is that, (when) dealing with young people you need to be down on their level and get with the program and use the jargon, and you can’t because you just look like an idiot, and that really alienates young people,” said Mezzini in an interview after the session.

“It’s a bit like parenting in the sense that you need to be friendly, but you are not their friend.”

Mezzini told delegates the black and white “sudden death” mentality of teenagers meant they were very quick to pass judgment and, once done, it was very difficult to retrieve the relationship, with the doctor pitted in an unwitting battle against the received wisdom of the patient’s peer group and Dr Google.
It was so important to get things right, Mezzini said, describing the adolescent contraceptive consultation as a “supercharged” encounter where the ground rules were different and there was much more at stake, with the opportunity to stave off the serious physical and psychological consequences of damaging early sexual encounters.

Building rapport, showing a genuine interest in the young person’s agenda and explaining why you were asking certain questions were a few good rules of thumb, she said, also offering advice on how to get the insistent 1% of parents out of the room (“Start with humour, but be firm if you need to, you’re within your rights to insist as a practitioner”).

Mezzini told delegates it was not enough to provide information about the mechanics of sex, contraception and STIs; doctors needed to explore the meaning of and motivations for sex and understand the inner world of their young patients. Skyrocketing numbers of teenagers presenting in distress to the nation’s Emergency Departments suggested that, at present, these needs were not being met, she said.

She also championed a robust sex and relationships curriculum in schools, lamenting the abolition of the Safe Schools program as a “terrible failure”.

“There is an overwhelming body of evidence that shows that in countries where kids get sexual health and relationship information at an age appropriate level — starting in primary school, all the way through their adolescence — they have lower rates of teenage pregnancy, lower rates of STIs and generally go better on all sorts of sexual health outcomes,” Mezzini said.

**Demand for labiaplasty soars**

Her comments were echoed by Balen, a Professor of Reproductive Medicine from the University of Leeds, who said the system was failing to adequately counsel teenagers on normal sexual development and future fertility.

A narrow focus on safe sex and contraception had seen numbers of teenage girls presenting for labiaplasty snowball over the past two decades, to represent 10 percent of all referrals to his paediatric gynaecology clinic.

Likening the practice to female genital mutilation, Balen said the majority of these young women presented with variations of normal anatomy and had unrealistic expectations gleaned from pornography and the Internet. He called for better education, not only of young girls but also doctors, on the issue.

Melbourne-based paediatric gynaecologist Sonia Grover said her experience was that patients often got their ideas about what “normal” labia looked like from sex education materials, and that one in four girls she saw were actually brought in by concerned mothers.

Balen said sex and relationships education – which has not been mandatory until recently in the UK – should not be delivered as a stand-alone subject but integrated throughout every subject of the curriculum in order to demystify the topic and discourage stigmatisation and taboo.
You can track Croakey’s coverage of the conference here.

Watch the interview

Dr Tonia Mezzini at #RANZCOG18

Tweet reports

@jedietri explains the facts on sexual reproductive health in adolescent girls and why adolescent gynae is important: 1 in 4 girls victims of sexual assault, almost 50% sexually active by 17, 12-14yrs is average age girls become victims of sex trafficking #RANZCOG18

#ranzco18

Next up @BalenAdam. Much focus on teaching young people about safe sex but little attention on development and fertility #RANZCOG18
You can track Croakey's coverage of the conference here.

On sexting, sex education and other health issues for children and young people
#RANZCOG18
On DSDs, @BalenAdam recounting past paternalism in approach and people presenting many years later in acute distress, not knowing whether/what operation was performed, lifetime of adverse effects, 'blighted lives'

#RANZCOG18

**Disorders of Sexual Development (DSDs)**

- May have presented neonatally e.g. congenital adrenal hyperplasia (CAH)
- May present in adolescence with primary amenorrhoea e.g. androgen insensitivity syndrome (AIS)
- Utero-vaginal anomalies may present with pelvic pain / dysmenorrhoea
- Often come in later years having researched and found out about our clinic, with immense lifetime burden of distress

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#ranzcg18
@WePublicHealth

Mx of DSDs - psychological support essential says @BalenAdam

#RANZCOG18

**The Management of Disorders of Sexual Differentiation**

Requires a multi-disciplinary team approach
Psychological support essential
Timing of surgery critical for best results
National networks of care, with a few specialised centres

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On sexting, sex education and other health issues for children and young people

#RANZCOG18
You can track Croakey’s coverage of the conference here.

Dr Alyce Wilson
@AlyceNWilson

Need to empower young people about their sexual and reproductive health - what is ‘normal development’ & their future fertility rather than merely focusing on safe sex and avoiding pregnancy @BalenAdam
#RANZCOG18

Nisha Khot
@Nishaobgyn

Adam Balen equating surgery for perceived labial dysmorphism in young girls to female genital mutilation. Better education of young girls regarding normal anatomy is critical
#ranzco18

#ranzco18
@WePublicHealth

Next presentation from Bec Deans on adolescents, consent and the law
#RANZCOG18
You can track Croakey's coverage of the conference here.

On sexting, sex education and other health issues for children and young people #RANZCOG18
You can track Croakey's coverage of the conference here.

On sexting, sex education and other health issues for children and young people
#RANZCOG18
Some interesting data on adolescents and technology. 8.8% have sent nudes, 20% of those aged 18. 15% of 11-15yo had received a sexual message. Consent is an issue, onward sharing of consensually sent/received sexual content another #RANZCOG18

**Age of consent and digital technologies**

In Australia, a non-representative survey of over 3,000 Australian young people under the age of 18 found:

- 8.8% would send or have sent a nude image
- 70% of 15-year-old respondents who stated they had done so

A random stratified sample of 400 Australian young people aged 11-15 who use the internet found 15% seen or received a sexual message

In many jurisdictions, provisions aimed at protecting young people from sexual exploitation can also be used to criminalise and prosecute the sexual self-expression of those under the age of 18 even when the young person is at the age of consent.

A survey of Australian teens and their sexting behaviour finds that 15-17 year olds must navigate sexual practices that can be both consensual and legal, but illegal to usually record.

#ranzcg18

Regarding individuals with an intellectual disability, parents have no authority to consent for procedures not in best interests - Family Court to rule. Sterilisation only permissible as a byproduct of treating other issues #RANZCOG18

**Marion’s case**

- Parental consent: there is no substitute
- Medical consent: there is no substitute
- Legal consent: there is no substitute

**Therapeutic vs non-therapeutic procedures**

- Parental consent: medical consent
- Medical consent: non-therapeutic procedures

Tonia Mezzini now taking us through contraception, STIs & sexual health of teenagers. Will often be your first contact #RANZCOG18
You can track Croakey's coverage of the conference here.

On sexting, sex education and other health issues for children and young people
#RANZCOG18

Tips for Engaging Young People

- Introduce yourself, clearly.
- Ask the young person to introduce you to others who may be present.
- This gives the young person a clear message that you are interested in them.
- Ask: What can help you with today?
- Prepare them for the sensitive nature of the questions.
- Acknowledge that it can be difficult to answer personal questions.
- Ask open-ended questions so that there is an opportunity for rapport building and engagement.
- The goal isn't just to elicit what is wrong with the young person.
- Check that you understand the young person's main concerns and difficulties; address their agenda.
- Before concluding, ask if they have any questions or anything more to add.
- Use the third person for sensitive questions - it can be less confronting.
  - e.g. Some of the young people I work with get stressed by their parent's relationship. Has that been an issue for you?
  - Have any of your friends had bad experiences with Facebook or Instagram, what would you do if that happened to you?

#RANZCOG18
On sexting, sex education and other health issues for children and young people

#RANZCOG18

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

And most importantly, engage with the young person, not with your computer screen! #RANZCOG18

Sexual Health Physician Dr Tonia Mezzini leading a brilliant interactive session on talking to young people about sexual health - ‘be friendly but don’t try to be their friends’ ‘don’t try and be cool, you are not cool, you are their doctor’ 😊😊 #RANZCOG18

Great session on supporting young people in healthcare ★

Show rapport, genuine interest in the young person’s agenda. Explain why you are asking about certain things. Use the encounter as an opportunity to do a HEADSSS assessment #RANZCOG18
Panel discussion

@WePublicHealth - Sep 17
Do adolescents prefer male or female fellows? Sometimes there are preferences, and sometimes these are from parents, says @jedietri. Most important thing is a consistent, welcoming approach #RANZCOG18

@WePublicHealth - Sep 17
Is it time to have sexual, reproductive & relationship education on the curriculum? Elaine Pretorius points to the 'sad' controversy around Safe Schools in Australia. @BalenAdam says not mandatory until recently in UK, public consultation underway #RANZCOG18

@WePublicHealth - Sep 17
Doesn’t have to be a discrete curriculum element but should be demystified and incorporated across the curriculum says @BalenAdam. Mezzini says all the evidence shows talking about sex early and openly results in lower teenage pregnancy and STI rates #RANZCOG18

@WePublicHealth - Sep 17
On the Texan experience, @jedietri says you have to ask very specific questions to get around what teenagers perceive as being sex and not being sex (oral, same same genital contact), reproductive literacy not great #RANZCOG18

@WePublicHealth - Sep 17
Unfortunately Mezzini says we presently have a very conservative government that is terrified if you talk about sex people will go out and have it, and if you acknowledge sex and gender diversity it is somehow contagious/causative #RANZCOG18

@WePublicHealth - Sep 17
On the question of labiaplasty demand in young people, Mezzini says labia library.org.au is a great resource. Grover says in Aus 1/4 of demands are actually driven by mothers; also says sex education materials rather than porn are giving unrealistic expectations #RANZCOG18

@WePublicHealth - Sep 17
Panel also recommending this book for a realistic view of the normal diversity of women's genitals amazon.com.au/Femalla-Joani:-... #RANZCOG18

@WePublicHealth - Sep 17
Panel recommends Minora for teenagers, applause from the audience. ‘If you’ve had a period I can put a Minora in’ says Sonia Grover. Mezzini says botox to the pelvic floor, pelvic floor relaxation exercise program before insertion can help with pain #RANZCOG18
You can track Croakey's coverage of the conference here.

On sexting, sex education and other health issues for children and young people #RANZCOG18

#RANZCOG18 @WePublicHealth - Sep 17
How much effort do you go to where parents are divorced to ensure everyone is on the same table? How hard do you push to get the parents out of the room? You can resort to chatting while examining behind a closed door. Within your rights to insist as a practitioner #RANZCOG18

#RANZCOG18 @WePublicHealth - Sep 17
Start with humour but be firm if you need to. You can't take a sexual hx with someone else in the room, be that a parent, a partner, says Mezzini. @jedietri says it is typically less than 1% of parents who insist on staying #RANZCOG18

#RANZCOG18 @WePublicHealth - Sep 17
On the divorce question, Deans says it depends on the complexity/reversibility of the procedure being contemplated. The law doesn't specify, so long as you have one parent, typically the primary caregiver, that is sufficient #RANZCOG18
What will it take to reduce maternal mortality?

Amy Coopes writes:

Expectant mothers continue to die from preventable causes at unacceptably high rates, with “shameful” disparities affecting society’s most vulnerable groups.

Maternal mortality was a major theme at this year’s annual scientific meeting of RANZCOG, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, with data presented from advanced and developing economies showing there are still improvements to be made.

Obstetric physician Dr Catherine Nelson-Piercy, from London's Kings College, set the tone for the meeting with a spirited opening presentation on the forgotten art of generalism in maternity care, in an era of “knobology”, and subspecialist “citadels”, where subspecialised Maternal-Foetal Medicine overwhelmingly focused on the unborn child.

“The mother is not just a vessel,” she told delegates.

While obstetricians are experts at managing the common complaints and complications of pregnancy, Nelson-Piercy said pregnant women in the UK continue to die from conditions like epilepsy, cancer or cardiovascular disease, with 75 percent of all maternal deaths occurring in women with comorbidities.
Australia was doing better on these measures, with lower maternal mortality than the UK (7 in 100,000 maternities compared with 9 in 100,000 and better performance on “indirect” or non-obstetric deaths), but Nelson-Piercy said this masked “shameful” discrepancies between outcomes for Indigenous and non-Indigenous mothers.

Maternal mortality for Indigenous women (13.8 per 100,000) is more than double that of their counterparts (6.6 per 100,000), with a sizeable gulf in cardiovascular deaths (3.9 vs 1.2/100,000), suicide (3.2 vs 0.6/100,000), hypertension and sepsis (2.6 vs 0.4 and 0.8/100,000 respectively).

**Address racism**

Darwin doctor Kiarna Brown, a Yadhiagana woman and one of just three Aboriginal and Torres Strait Islander obstetricians nationwide, captivated colleagues with a powerful talk on closing the gap, which centred on the story of a teenage mother who had died following a litany of missteps in her care.

“For Aboriginal people it’s not about illness,” she said in an interview after the plenary. “It’s not about the ankle, it’s not about the kidneys, it’s not about the sugars. It’s about deep cultural strength, it’s about connection to community, it’s about connection to country. It’s about being strong within ourselves, and then the health stuff comes.”

Brown told colleagues the statistics were well known – Indigenous women faced a disproportionate burden of chronic disease, faced a 10-year life expectancy gap, and their babies were more frequently born preterm and with low birth weight “so they’re already starting 10 steps behind.”

What was less well understood was why this was the case, she said, urging delegates to educate themselves about the Aboriginal model of health (treating the person and their community in a cultural context), and the diversity of communities and inadequacy of a one-size-fits-all approach.

She also urged delegates to reflect upon and acknowledge their own privilege, and to understand the concept of remoteness – something that encompassed much more than geography and was about loneliness, loss of culture and discrimination.

“Please don’t be fooled into thinking that racism doesn’t exist,” she urged colleagues. “Almost 28 percent of Australians demonstrate racism to Indigenous Australians, and racism leads to poorer health outcomes. This is fact.”

“If you look at the historical context, Aboriginal people weren’t even allowed in hospitals one, maybe two generations ago. So our modern doctor needs to understand that, and needs to be aware that it’s their responsibility to be culturally safe and provide culturally appropriate care.”
Advocacy matters

Outgoing RANZCOG President Steve Robson said it was essential to acknowledge the lasting impacts of occupation on health outcomes for disadvantaged women, and called on the College to step up its advocacy for Indigenous, migrant and CALD populations and intensify collaboration with groups such as NACCHO, the Australian Indigenous Doctors Association and the Migrants Council of Australia to drive policy reforms.

“We are not so good at looking the broader social determinants,” said Robson. “Yet the social determinants of the conditions we treat is utterly important.”

He presented data showing stark disparities in maternal mortality by socioeconomic quintile (10 in 100,000 for the lowest, 4 in 100,000 for the highest), particularly for those deaths considered medically preventable (1 vs 0.2 in 100,000).

Though this was beyond the power of any one person to address, Robson said it was vital that each and every doctor be a strong advocate for the women they served, at all political levels.
Reforms needed

In the UK, Nelson-Piercy said mortality had declined steadily overall in the past 20 years, but progress had been inconsistent on “indirect” deaths from things like cardiac conditions or influenza, highlighting the importance of not just multidisciplinary involvement but the need for a generalist to “project-manage” care.

Pregnant women with pre-existing medical conditions or conditions that developed during but not as a direct result of their gestation could attend multiple clinics at different sites, overseen by different doctors, with very poor communication between care providers, she said.

Few specialists were well versed in the care of pregnant women, she added, with some disciplines “cowboys” who didn’t appreciate the nuances and others overly cautious, resulting in either over or undertreatment.

What was needed was a generalist – “not instead of, as well as” – who knew how to manage pregnant patients but was also experienced in and not afraid of conditions like asthma, epilepsy, bowel and lung disease, drug use and other common and less common comorbidities, she said.

There were significant opportunities for improvement with better planning and counselling around known conditions including mental health, optimisation of medications before pregnancy, and early referral where required. There were also gains to be made in postpartum health, Nelson-Piercy said, urging that the continuum of care continue beyond the labour ward.

One of former health secretary Jeremy Hunt’s final acts in the role was to announce funding for the training of a dozen obstetric physicians and establishment of maternal medicine networks to try and combat preventable maternal deaths in the UK, said Nelson-Piercy. In the UK, the obstetric profession had also moved to split foetal and maternal medicine into distinct entities in recognition of their sometimes competing demands, she added.

The calls for more generalists and a greater focus on equity in women’s health were echoed by both Robson and outgoing AMA president Dr Michael Gannon, who said funding of public hospitals, GPs and perinatal psychiatry, and access to services were real threats to the equitable provision of maternity care.

“The move towards subspecialisation, to forming citadels of luminous brilliance in our cities, is a threat to the care we can provide in our outer suburbs, rural areas and to needy groups,” Gannon told delegates.

Global perspectives

Oxford Professor Chris Redman offered a global perspective on the issue, sharing his experiences at the helm of CoLab, an international research consortium on adverse pregnancy outcomes funded by the Bill and Melinda Gates Foundation.

Outlining the scale of the global challenge, Redman said an estimated 350,000 expectant mothers died every year, with 2.5 million stillbirths and 2.5 neonatal deaths and 15 million preterm births, 60 percent of which occurred in low and middle income countries.

Where data was most needed, it was least often available, he told delegates, with only one of the top-ranking 10 countries in terms of maternal mortality – Cameroon – having such information available, and the remaining nine based on estimates alone.

“These are the black holes of tragedy, where no one knows what is going on,” Redman said.
He shared some of the challenges attempting to roll out large-scale data collection and standardisation in developing nations, where records were often kept on paper and authorities were suspicious of digitisation and storage of information in offshore repositories.

Unless such information was standardised and retrievable it could not be shared, said Redman, adding that “unshared data cannot serve a global vision of what is possible” in improving maternal and perinatal health.

**Solomon Islands**

Dr Manarangi De Silva shared her experiences of maternal mortality, following a six-month secondment to the Solomon Islands, where the death rate was 114 in 100,000 and just four consultants and six registrars serviced the whole country, delivering 5,600 babies each year.

In a country devastated by civil war and trying to find its feet after the end of a 14-year peacekeeping mission, De Silva said infrastructure remained a major issue, with the basics most doctors took for granted such as saline, antibiotics and other medicines in shortage, and two-thirds of women experiencing intimate partner violence.

Maternal deaths were commonly due to hypertensive disorders, haemorrhage and infection – causes not often seen in Australia – as well as from communicable diseases such as malaria, dengue, tuberculosis and undiagnosed Hepatitis B.

One-third of women died anaemic due to malnutrition, parasitic infections and vector-borne illness, and one in three maternal deaths had not received antenatal care, while a quarter perished due to a lack of blood products. De Silva said there was no formalised blood donation program in the Solomon Islands and patients were reliant on family to give blood if it was needed.

Five percent of women died because they couldn’t get to an operating theatre in time when complications arose, with the average waiting time for emergency surgery 170 minutes.

There was also a special session on obstetric issues in Indonesia, where the maternal mortality rate had seen an uptick in 2013 to 359 per 100,000 – a 20-year high and among the highest rate seen in Southeast Asia – with speakers presenting on management of conditions including pre-eclampsia, cardiomyopathy and placenta accreta.
Watch the interview with Dr Kiarna Brown

Dr Kiarna Brown at #RANZCOG18

Tweet reports
Tweets below by Amy Coopes for @WePublicHealth

Dr Nelson-Piercy

First up @nelson_piercy from @KingsCollegeLon. Compares Australia & UK data. Australia doing better on indirect maternal deaths (flu, cardiac), but 'shameful' disparities between Indigenous & non-Indigenous mothers
In order to reduce maternal mortality further, multidisciplinary care is key. O&Gs are really good at managing common conditions of pregnancy but not pre-morbid chronic conditions like epilepsy, which are still resulting in deaths, says @nelson_piercy #RANZCOG18

Training doctors a 'pluripotential stem cell' but this lost as specialisation evolves says @nelson_piercy, lamenting the loss of the general physician #RANZCOG18

Pregnant women with comorbidities can attend multiple clinics at multiple sites with little communication between, at the expense of the patient, says @nelson_piercy. Compounded by fact that maternal-foetal medicine is often 'foetal-centric' #RANZCOG18

The status quo and joint clinics are simply not enough, says. "The mother is not just a vessel", overlooked in the interests of the foetus, says @nelson_piercy of a disconnect between maternal and foetal medicine #RANZCOG18

Sepsis has lessons for O&G - there needs to be a project manager shepherding care where lots of different doctors & specialties may be involved. @nelson_piercy also advocates for obstetric intensivists #RANZCOG18
'Not instead of, as well as' says @nelson_piercy of the obstetric physician vs the O&G specialist. Complementary, project management, translation. See and are not afraid of asthma, epilepsy, bowel disease, lung disease, drug use in pregnancy, rare & acute presentations #RANZCOG18

Some specialists are cowboys (gastro) and others are overly cautious in pregnancy (derm) says @nelson_piercy of the troubling silos affecting pregnant women #RANZCOG18

We need Maternal medicine networks
No-one questions or doubts or had difficulty accepting the need for:
• Neonatal networks
• Fetal Medicine networks

If we are going to impact on indirect deaths from medical conditions we need Maternal Medicine Networks!!
Many opportunities for improvement in maternal mortality says @nelson_piercy. Planning and counseling, early referral is so important. Huge gains in postpartum health as well - continuity of care must continue into the puerperium #RANZCOG18

Key improvements needed

- There remain multiple opportunities to reduce women’s risk of complications in pregnancy through early and forward planning of the care of women with known pre-existing medical and mental health problems
- Provision of appropriate advice and optimisation of medication prior to pregnancy
- Referral early in pregnancy for the appropriate specialist advice and planning of antenatal, intrapartum and postnatal care
- Effective postnatal provision of advice concerning risks and planning for future pregnancies
Words are so important says @nelson_piercy. You shouldn’t tell women ‘you can’t get pregnant’ on a certain medication - they hear something different to what you intended #RANZCOG18

You mean ‘you should not get pregnant while taking this medication because it’s teratogenic’, but what she thinks you mean is ‘this drug is a contraceptive’ and stops her contraceptive measures. Many unplanned, high-risk pregnancies happen this way says @nelson_piercy #ranzcog18
Dr Kiarna Brown

Why am I here? Because I have a story to tell @kiarna_brown #RANZCOG18

Incredibly moving, sobering story of a 19yo pregnant woman from a remote community with lupus who came in and out of the health system, and died a few months after her baby was born, shared by @kiarna_brown #RANZCOG18

The Gap, and why it exists. Loss of culture, loneliness, racism - remoteness is not just about geography @kiarna_brown #RANZCOG18
What will it take to reduce maternal mortality?

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

Current State of Aboriginal Women’s Health

- Poorer health than other Australian women
- Expect to live almost 10 years less
- Younger population
- More babies, at younger ages
- Lower birthweights
- Good rates of antenatal care
- Higher rates of cervical cancer
- Sexual health remains a significant health issue

Breaking down barriers

1. Understanding remoteness
2. Being aware of under-servicing
3. Being properly informed
4. Knowing your advantage

Please don’t be fooled into thinking that racism doesn’t exist. Almost 28% of Australians demonstrate racism to Indigenous Australians, says @kiarna_brown. Racism leads to poorer health outcomes, this is fact #RANZCOG18
On understanding your advantage, @kiarna_brown shares this powerful video with #RANZCOG18

$100 to the winner of the race (Subtitles)
SHOP NOW: HTTPS://kaylacastelle.wixsite.com/castelle $100 to the winner of the race (subtitles)
youtube.com

Dr Steve Robson

Underway at Day Three of #RANZCOG18 with the President's Address from @DrSteveRobson and what promises to be a thought-provoking session from @connankf on gender equity in O&G leadership

#AustPH2018 @WePublicHealth · Sep 18
“The most shocking low point of the last 2 years was having a journalist ring me and say do you think the College hates women?” - @DrSteveRobson on the pelvic mesh scandal #RANZCOG18

#AustPH2018 @WePublicHealth · Sep 18
If this is a perception in our elected officials in Australia at least then we really need to have a think about what we are doing and where we are going, says @drstevrobson #RANZCOG18

#AustPH2018 @WePublicHealth · Sep 18
We need to say what are we actually about? I don’t think there is anyone in this room who doesn’t want the absolute best care for women - @drstevrobson #RANZCOG18

What will it take to reduce maternal mortality? #RANZCOG18
What will it take to reduce maternal mortality?

#RANZCOG18
What will it take to reduce maternal mortality?

If we want to provide great health care and improve the health of women @drsteveborahson says there is a huge role for generalists. "And the social determinants of the conditions we treat is utterly important" - touches on housing and food security for Indigenous people #RANZCOG18

#AustPH2018 @WePublicHealth · Sep 18
Robson shows plateau in women’s health from 2010 and highlights disparities by socioeconomic quintile. Only way to deal with this is at a policy level - beyond any individual doctor - but says individual doctors must also be strong advocates at all levels of politics #RANZCOG18

#AustPH2018 @WePublicHealth · Sep 18
Robson says essential to better collaborate with groups like @NACCHOAustralia, @AIDAustralia, Migrants Council on driving a policy agenda. "But the most important partnership is with the women we serve" #RANZCOG18

Ingredients for success @DrSteveRobson #RANZCOG18

What will it take to reduce maternal mortality?
What will it take to reduce maternal mortality?

Dr Chris Redman

Last up for today, Chris Redman from @UniofOxford on the Global Pregnancy Collaboration #RANZCOG18

Placentally-mediated diseases exacerbated by poverty the focus of CoLab, which was founded by @gatesfoundation #RANZCOG18

Redman says there are 3 genomes at play – the baby, mother and placenta. Environmental factors such as obesity also play a role #RANZCOG18
You can track Croakey’s coverage of the conference here.

Data is available for free to LMIC researchers and comes in Spanish & Portuguese says Redman #RANZCOG18

#AustPH2018 @WePublicHealth · Sep 18
Redman talking about some of the challenges of rolling out the project in Tanzania. Now looking at a prototype of real-time birth registry database, need funding #RANZCOG18

Where the data are most needed they are least available, says Redman #RANZCOG18. Of 10 worst countries only one (Cameroon) has actual data, the rest are estimates.'These are the black holes of tragedy where nobody knows what is going on.'

Redman says the solution lies in unlocking the ‘treasure trove’ of paper archives via rollout of an electronic delivery register #RANZCOG18

In summary #RANZCOG18

Summary

- Perinatal data would be several orders of magnitude more powerful if it were collected in the same data format on the same data system
- Research databases would be cheaper if they were not reinvented for each new study
- The benefits of harmonised data should not be limited to High income countries
- Access to universal, reliable, perinatal data is the key to improving maternal and perinatal health
- CoLab is pioneering a unique concept in the COLLECT & CONNECT systems that will resolve these problems
- This requires international interest, commitment and consensus

Need to bring all stakeholders together starting at the top with the @WHO, concludes Redman. And of course, money is a constant issue #RANZCOG18
What will it take to reduce maternal mortality?

Dr De Silva

Next up: Manarangi De Silva on maternal mortality in the Solomon Islands

#RANZCOG18

MATERNAL MORTALITY AT THE NATIONAL REFERRAL HOSPITAL IN HONIARA, THE SOLOMON ISLANDS OVER A 5 YEAR PERIOD

HOW CAN WE IMPROVE?

Dr. Manarangi De Silva
Mercy Hospital for Women, The University of Melbourne
The National Referral Hospital, Honiara, Solomon Islands

Following a civil war the country is struggling with basic health infrastructure, medicines shortages, poor access. 64% of women have experienced IPV and 73% of men in the country view IPV as acceptable

#RANZCOG18

4 consultants and 6 registrars service the whole country, with 5,600 births every year

#RANZCOG18

99% of maternal mortality occurs in the developing world

#RANZCOG18

Maternal mortality 114:100,000, compared with 6.8 in Australia. A woman in the Pacific is 3x more likely to die as a result of pregnancy & childbirth than a woman in Southeast Asia

#RANZCOG18
Top causes of death: hypertensive disorders, haemorrhage, infection. All causes not often seen in Australia. Indirect deaths due to communicable diseases: malaria, TB. 50% due to undiagnosed Hep B. 36% were anaemic - malnutrition, parasites, malaria & dengue #RANZCOG18

One third of women who died did not receive antenatal care, 5% died due to lack of access to theatre. LSCS rate is 10% but average time to OT for an emergency is 170 mins. 24% died due to a lack of blood products #RANZCOG18

Dr Alyce Wilson @AlyceNWilson

@Littlerang7 discussing lack of blood and blood products contributing to high maternal mortality rates in Solomon Islands. Blood donors and skilled lab staff crucial! #ranzCog18
Calling for a community-wide discussion about the complexities of genetic screening

Ten thousand couples across Australia are set to have genetic carrier screening for conditions such as cystic fibrosis, spinal muscular atrophy and fragile X syndrome, as part of a $20 million pilot study.

The study is funded via a $500 million allocation for genomics medicine announced in the May Federal Budget, which was welcomed by medical researchers but has also generated debate about some of the equity and ethical issues involved.

Some of the wide-ranging questions raised by genetic screening were also discussed at the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) conference in Adelaide.

Amy Coopes writes:

In an era where it's possible to distil our makeup down to its most fundamental building blocks, offering a glimpse not only of who we are but what we have the potential to become, how prepared are we for the answers and their implications?

This was the essence of a thought-provoking talk to women’s health specialists at their recent annual summit in Adelaide, where obstetrician Dr Steve Robson offered an insight into the ambitious Australian Reproductive Carrier Screening Project.
The project – a $20 million pilot study – aims to roll out extended genetic carrier screening for couples intending to start a family, in the hopes of reducing deaths and serious morbidity from heritable causes.

Called “Mackenzie’s Mission”, the project follows advocacy from the parents of Mackenzie Casella, who died aged seven months from spinal muscular atrophy, an inherited condition of which both her parents were unaware they were carriers. An estimated one million Australians are directly or indirectly affected by genetic disorders.

Presently in the preliminary phases, the project will initially examine a panel of about 500 genes across 10,000 couples, looking to refine a potential list for use in population-wide screening, Robson told the annual congress of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG).

Bioethical debate

As the medical specialty concerned with the conception, gestation and delivery of children, Robson said obstetricians could soon find themselves at the forefront of one of the great bioethical debates of our time: “the fundamental essence of being human”.

Robson said:

“It is part of being human that we are imperfect, and we are now on the threshold of an era where it is possible to dissect in minute detail all of the genetic imperfections that each of us carry.

It gives us a choice: if we are going to have a family, do we accept imperfection? At what level do we say this is not an imperfection I want to accept in my children? Should you even be given that knowledge?”

Genetic technology had advanced at such a rate Robson said it had run “far ahead of society’s capability of understanding what it can do”, including the medical professionals who would be tasked with counselling the public on the risks, benefits and implications of screening for potential risks.

Describing technology as the “easy” part of the equation, Robson sounded caution on the enormous, perhaps to some degree inconceivable, psychosocial and ethical dimensions to the project, which he likened to “intelligence designing humans”.

At a fundamental level, there were questions about where you set the bar – which conditions should be included in standardised screening, and on what basis: because it imposed a certain burden of disability; because that disability was intractable or difficult and therefore costly to treat?

“Do we look at it from the point of view of what’s most economical: will taking these diseases out of the gene pool in Australia be an economic plus, will it be an economic minus?” asked Robson.

“Is it right to even look at it in economic terms, or is it something that should be beyond economics and purely be around the morality of illness?”

If the screening panel ultimately included genes for 500 conditions, how much should a prospective couple need to know about each of these to make an informed choice when “most genetic specialists wouldn’t have a clue about most of the conditions on this list or what they do, and in fact even in the sum of all human knowledge these conditions may be so rare that people don’t know a lot about them”?
Equity matters

How could you guarantee that this information was accessible to every person in the population, no matter their level of education or proficiency with English or degree of literacy with the Australian health system, asked Robson.

“One of the big things that frightens me very strongly is the concept of the genetic haves and the genetic have-nots, that the person who is well informed, well-heeled, can afford & knows what the options are will have a completely different family or diversity in their family to the poor person who can’t afford it, or can’t understand it, or doesn’t know how to make a choice or is isn’t helped to make a choice or isn’t made aware of the options,” he said.

How much information should be shared with the couple about the findings and in what format was another thorny question, he said.

Currently, it was being proposed that screening would be offered to couples rather than individuals, and only conditions for which both were found to carry a genetic mutation would be reported back, “partly to simplify things”.

But what would happen to the data, and to the tested material itself? Would it be stored, and if so, where? What protections would there be on other, or future uses? “I think there is enormous concern about, for example, insurance implications, work implications,” he said.

Robson said these were fundamental questions beyond individual doctors or parents to adjudicate, but a discussion that needed to be had “as a community as a whole”.

“The technology’s totally available and it’s becoming affordable and society needs to have this discussion now before it’s frankly taken over by commercial interests, we need to know where we’re going and have a voice as a community,” he said.

“There are many complex issues out there that we need to come to grips with and we need to come to grips with them soon.”

Watch this interview with Dr Steve Robson

Watch from 10 mins 30 secs in for the discussion on genomics.
Tweet reports
The tweets below are from Amy Coopes tweeting for @WePublicHealth.

Outgoing @ranzcoh President Steve Robson stepping up for the plenary on Mackenzie's Mission & extended carrier screening in Australia #RANZCOG18

Meet the couple who lost their little girl, but inspired a $500...
The Government has backed a pilot study called Mackenzie’s Mission.
abc.net.au

Robson says advances in technology are quickly outstripping the ability of medical professionals to properly counsel people on the implications of screening and doing it in a best practice fashion #RANZCOG18

The ambitious Australian Reproductive Carrier Screening Project. Need to consider the ethics, psychosocial impacts, barriers and health economic implications, says Robson #RANZCOG18

The Australian Reproductive Carrier Screening Project (ARCSP)

- The goals of the project will be to develop and implement processes for delivering screening, to build capacity towards scaling up to a population-wide level for the whole of Australia, and to evaluate the psychosocial impacts, ethical issues, possible barriers to successful uptake and health economic implications of the proposed program.
- Screening will be conducted on a couples basis, with both partners being tested for a large number of genes (~500) associated with severe disorders affecting children.
- However, this does not mean that couples will receive 500 results – an important qualification for the psycho-social and ethical acceptability of this approach.
There are many conditions that can be screened for - how do you choose which ones to include? They may be rare, but someone will be affected. Robson says one million Australians are affected directly or indirectly by genetic disorders #RANZCOG18

Initial plan to look at 10,000 couples and a panel of about 500 genes. Ethical issues must be paramount, says Robson. Equity of access must be at the heart of this project. We don’t want genetic haves and have nots #RANZCOG18

Population literacy around these very complex issues will be crucial, as will upskilling of the O&G workforce to capably counsel families #RANZCOG18

The technology is easy, the psychosocial ramifications are extremely hard, says @DrSteveRobson #RANZCOG18

We have scarce resources and it is a difficult decision to make, how to apportion these resources. It’s beyond us, it’s a community-wide discussion, says @drsteverobson. The choices that we make about how we have our families is so fundamental to who we are #RANZCOG18
A final wrap of the news from #RANZCOG18 – with tweets, snaps and selfies

Below is our final report from the recent Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) conference in Adelaide.

It includes a selection of tweets from presentations, posters and social events, and a wide-ranging interview between Amy Coopes and former AMA president Dr Michael Gannon.

Gannon stresses the importance of generalism in medical training, so that specialist obstetricians and gynaecologists are equipped to work in rural and outer metropolitan areas and other areas of needs. He raises concerns about some of unintended outcomes from responses to the pelvic mesh disaster, and also shares personal insights into the heavy demands on AMA presidents.
You can track Croakey’s coverage of the conference here.

Tweet reports

Sarah Jane Perkes @PerkesSarah · Sep 15
Always mind blowing to listen to Prof Arebinih #RANZCOG18

Kiarna Brown @kiarna_brown · Sep 15
What a privilege to hear @ArebinihKerry speak about the @First1000DaysOz It’s amazing to be in the presence of such enormous intelligence and leadership. #RANZCOG18 #letswhm

AIHWomen @AIHWomen · Sep 15
Wonderful visual storytelling from the NPY Women’s Council about Ngangkari traditional healers - def going to revisit their resources #women #RANZCOG18
You can track Croakey’s coverage of the conference here.

A final wrap of the news from #RANZCOG18 – with tweets, snaps and selfies

#RANZCOG18
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#RANZCOG18

Croakey

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

A final wrap of the news from #RANZCOG18 – with tweets, snaps and selfies

#RANZCOG18

Dr Kirsten Connan @Connenid · Sep 18
John Lynch from @UniofAdelaide discussing research databases for risk prediction. #Pregnancy an opportunity to identify at risk children and create strategies to reduce intergenerational disadvantages @ranzcog #ranzcog18

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susan hickson @susanjhickson · Sep 16
Thanks to @carmelapestell, @SueMiers1 and @DrSteveRobson for leading the discussion on alcohol & pregnancy this morning at #RANZCOG18
You can track Croakey's coverage of the conference here.

A final wrap of the news from #RANZCOG18 – with tweets, snaps and selfies

Why is it important?

- Rates are rising
- Implications are serious
- Frequently under diagnosed and mis-diagnosed
- Poor antenatal outcomes
- Antibiotic resistance is emerging
- Closing the gap

Dr Alyce Wilson @AlyceNWilson · Sep 17

Representing the @HMHB_Burnet team and sharing some of our research findings on obstetric danger signs and emergency planning @ranzcg ASM @BurnetInstitute @MJLScoular #RANZCOG18

Croakey
“Conference News Service”
You can track Croakey’s coverage of the conference here.

## RANZCOG18

### In Australia

**Current**
- Gynaecologists consider a vaginal hysterectomy
- Failing that, gynaecologists often offer an open/abdominal approach

**Future**
- Gynaecologists consider a vaginal hysterectomy
- Failing that, they offer a laparoscopic procedure or facilitate a second opinion

Uptake of TLH in Australia remains remarkably slow

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**@SHQHealthQuarters · Sep 19**

Congratulations from us to our superstar Medical Director, Dr Richelle Douglas, who took out the Early Career Researcher award at the @ranzcog Annual Scientific Meeting! We are SO proud! 😊🎉 #RANZCOG18

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**EARLY CAREER RESEARCHER AWARD**

Richelle Douglas

Researcher of the Year in Young People in Australian Cities
Why and What Should Be Done?

Sponsored by WILEY

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A final wrap of the news from RANZCOG18 – with tweets, snaps and selfies

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**Croakey “Conference News Service”**

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

A final wrap of the news from #RANZCOG18 – with tweets, snaps and selfies

#RANZCOG18

Can we address inequity in Women's Health?

- Inadequate Public Hospital funding, induction of VHS services.
- Private patients in Public Hospitals: decreased access to care for women without choice, decreased access to screening, decreased access to surgery.
- Mackenzie's Mission: equal access to IVF/GDP?
- Senate inquiry into Transvaginal Mesh: equal access to sub-specialist Urogynaecological expertise?
- Laparoscopic Hysterectomy: does standard standard equal affordable access to AGIS Level IV+ Surgeons?
- Where are ATSIs and CALD women in all of this?
- Where is funding for General Practice and Perinatal Psychiatry?

#RANZCOG18

"Conference News Service"
You can track Croakey's coverage of the conference here.

A final wrap of the news from #RANZCOG18 – with tweets, snaps and selfies

Watch the interview with Dr Michael Gannon
You can track Croakey’s coverage of the conference here.

A final wrap of the news from #RANZCOG18 – with tweets, snaps and selfies

Snaps and selfies

inspectorcharlie @inspectorcharl2 · Sep 18
Adelaide trainees represent! #ranzcoh18

Dr Kirsten Connan @Connanid · Sep 18
Sitting next to the grandfather of urogynaecology in Adelaide and the person behind the sub specialization program for urogynaecology @ranzcoh #ranzcoh18

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“Conference News Service”
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A final wrap of the news from #RANZCOG18 – with tweets, snaps and selfies

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“Conference News Service”
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A final wrap of the news from #RANZCOG18 – with tweets, snaps and selfies

#RANZCOG18
Twitter analytics

Warm thanks to Amy Coopes for covering #RANZCOG18 for @WePublicHealth and the Croakey Conference News Service, and to all conference tweeps. Read the Twitter transcript here. The analytics below are from Symplur, and for the period of Croakey’s coverage: 10-30 September 2018. They show more than 20 million Twitter impressions for the conference hashtag over this period, with 404 participants in the Twitter stream.

Croakey Conference News Service

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