STOP

- Promoting a personal/professional agenda/view
- Believing that IOL is bad
- Special status & restrictions on mifespristone
- To consider trans patients and their needs
- Sidelining sexual and reproductive health
- Firefighting in O&G and focus back upstream to avoid unwanted pregnancies
- Talking exclusively about health care
- Practising on patients
- Trivialising or ignoring nausea and vomiting in pregnancy (NVP); failing to recognise the physical, psychological and economic costs; being frightened of treatment through ignorance/fear and failing to engage expert help
- To think about your cultural lens and assumptions
- Using customised growth charts
- Ignoring trauma and violence among O&G patients
- Switching pregnant women to buprenorphine-only preparations
- Always administering misoprostol PV in miscarriage management: buccal just as effective with better patient satisfaction
- Assigning trainees unachievable research projects, sending them to medical records for hours on end, thinking about research (and other requirements) as a box-ticking exercise
- Listening only to medical experts at medical conferences
- Aboriginal and Torres Strait Islander stillbirths and other adverse perinatal outcomes
- Preventable stillbirths by implementing what we know works
- Taping, pulling, vertical skin incisions, use of drains, staples to skin, negative pressure wound devices in LSCS for obese patients
- Counselling about chance of VBAC based on population-level epidemiology
- Assuming we know what women want
- Thinking we can be good at everything; core training in outdated surgical modes
- Believing the status quo is good enough; being falsely reassured by growth scans with EFW >10th %ile
- Using SFH, customisation
- Use of minislings, anterior colporrhaphy, needle suspension procedures, MMK procedures for incontinence: choose a safer more effective option
- Avoiding the topic of sexuality because of time constraints, lack of knowledge, insecurity or because the topic is potentially irrelevant for patient dynamic
- Delivering monochorionic twins immediately if one dies; coagulation studies in single MCDA twin demise
- Thinking that oestrogen or only pharmacological agents can treat hot flushes and night sweats in menopause
- Labelling monochorionic twins as presenting/twin 1 (use L/R or sup/inf); dating by the larger twin in first trimester (use an average of CRL); routine use of CTG in twin monitoring
- Thinking contraception is somebody else's business
- The black box warning on vaginal oestrogen that leads to unnecessary fearmongering
- Checklist screening for pre-eclampsia

- Seeing severe hypertension as simply high BP rather than an outcome to be avoided
- The war in obesity
- Using opioids, they rarely work and have a high risk of dependence
- Considering evaluation for deep infiltrating endometriosis as a subspecialist assessment

START

- Midwifery continuity of care for all women every pregnancy
- Sharing with women what we know and what we don't know
- Discussing preferred timing of delivery with women
- Wider training for GPs and RANZCOG trainees on use of mifepristone
- To build knowledge on trans health
- Prioritising equitable abortion service provision; the dialogue re conscience, commitment and objection within the profession and how to accommodate this for equity of access
- Addressing the elephants in the room – contraception and safe abortion – and influencing governments on these
- Talking about health
- Building expertise in RANZCOG educators
- Assessing and classifying NVP with validated instruments (PUQE-24); identifying best place/expert/treatment and following algorithm to provide best care; reassessing regularly and ensuring appropriate antenatal monitoring; auditing your practice
- Checking out cultural competence resources
- Using intergrowth charts
- Asking your patients about trauma and violence and thinking about how you can be a safety ally
- Thinking about systems to support your team working with women with drug and alcohol dependency; making sure all women using opiates have access to naloxone; considering long-term relapse prevention for methamphetamine users; screening all women for substance use regardless of first impression; recognising that screening often misses women using alcohol and prescription medications
- Adding mifespristone 200mg PO followed by 880mcg single buccal dose for miscarriage management; pre-treating cervix with 400mcg SL or PV misoprostol prior to curettage
- Embracing government
- Properly supporting trainees in research teams, thinking about learning as lifelong, being a role model for discussions around EBM
- Listening to the lived experience of the women and families we care for
- To support or develop ACCHS delivery of antenatal care and treatment in collaboration with hospital services
- Talking about stillbirth; ensuring all clinicians involved in maternity care are aware of Safer Baby resources
- Antenatal counselling, preparation & planning, practice/simulation, ensuring abx >30min before KTS, postop oral abx (BMI dependent?), enhanced recovery practices in LSCS for women with high BMI
- Using individualised approaches to TOLAC counselling

- Asking women about what they think; providing more funding for well-designed research
- Doing more endometriosis research
- Recognising the changing nature of procedural gynaecology, including volumes and limits; hysteroscopy training at a core program level given volumes; the conversation around sharing remuneration for referrals
- Adding foetal growth velocity into your overall assessment of placental function; utilising 39-week delivery in cases where there are concerns about poor placental function
- Using MCA dopplers more widely to aim to reduce stillbirth
- Following the ACSQHC care pathway on incontinence; discuss mesh and non-mesh options; give patients ACSQHC or UGSA info; performing the surgery you are good at; follow up your patients and audit your cases for the UGSA database; attend M&M meetings
- Recognising the impact of a twin death in dichorionic twins; consulting with specialist paediatric neurologists in single MCDA twin demise
- Offering non-pharmacological and non-hormonal treatments for troublesome menopause symptoms
- Doppler for cerebral redistribution on selective FGR in monochorionic twins; regular dopplers for measuring twins
- Discussing postnatal contraception during pregnancy
- Educating patients and doctors about cosmetic vaginal surgery; regulation of the sector; standardising definitions and validating questionnaires for research
- Public education on use of vaginal oestrogen for pelvic floor symptoms; asking every woman about pelvic floor symptoms to tackle minimisation of symptoms
- Multimodal screening for pre-eclampsia
- Antihypertensive therapy to prevent severe hypertension, and consider oral best route
- Discussing health rather than focussing on weight

CONTINUE

- Using ondansetron in first trimester
- Asking women and families what matters to you
- Shared decision making
- Improving women's access to and knowledge of reproductive healthcare, both contraceptive (esp LARCs) and abortion services
- Developing skills in trans health
- Developing a curriculum for sexual and reproductive health; advocating for appropriate and affordable services locally, nationally and regionally
- Striving for the sustainable development goals
- Practising holistic medicine
- Using simulation and building it into competency for all future RANZCOG doctors
- Research into treatment of NVP; upgrading and investing in resourcing to assist women, especially ambulatory care and psychological support
- Cultural competency training
- Responding to trauma and violence among your patient population

- Offering pregnant women with drug and alcohol dependency buprenorphine-suboxone sublingual film
- Recognising that providing best practice care for vulnerable women requires investment of significant time and resources but has the potential to make a huge difference
- Using misoprostol alone for retained products (no evidence yet that mifepristone helps in these patients); waiting 36-48h post-mifepristone (24h still acceptable if treatment is time critical but PV or buccal route preferred)
- Valuing the place of research in clinical training and practice; increasing university presence at peripheral sites; supporting trainees to undertaking clinical research where they have capacity and desire; encouraging trainees to present their work
- Patient-centred, individualised care
- Ongoing review of the effectiveness of service delivery
- To strive for best outcomes for mothers and babies
- Proprietary traction devices, preop abx >30 min before incision, 2 layer closure of uterus, closing fat layer, subcuticular to skin in LSCS for women with high BMI
- Emphasising a shared decision making approach
- Providing better and psychologically-informed interventions and interactions with patients; advocate for better understanding and acceptability of talking about women's health and bodies
- To monitor your own surgical skillset; edit out procedures of high complexity with low volume if there is a colleague that will provide a better outcome for the patient
- Using EFW with international growth charts (IG21)
- Being curious about sexuality – patients will be relieved that you start the discussion
- Monitoring after single-twin demise; use of magnesium sulfate and steroids when planning delivery following singe MCDA twin demise
- Offering HRT to young menopausal women without contraindications; offering vaginal oestrogen to breast cancer patients after discussion with their oncologists
- Looking for EFW discordance >20% at term in monochorionic twins
- Using LARCs because they are the most effective form of contraception
- Good communication with parents about known and unknown risks
- Emphasising correct information on topical oestrogen use and encouraging conversations with family, friends and health care providers
- 150mg aspirin for management of pre-eclampsia
- Treating non-severe hypertension in pregnancy/postpartum because prevention is best
- From mesh: Working together, fostering MDT, and putting patients at the centre, ensuring adequate training, developing registries for real-world evidence, restricting new technology to research settings
- Holistic care for women with high BMI

It's a wrap: https://twitter.com/ranzcog/status/1184688674853871616