OBS + GYNAE

Obstetrics and Gynaecology Clinical Elective

Sydney, Australia

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Final Year MBBS

Supervisor – Dr Kirsten Black

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Objective 1 - What are the prevalent Obstetric and Gynaecological conditions in the indigenous population of Australia and how do these compare to the UK?

I have focused on the indigenous population of Australia as there are more pronounced differences when compared with the UK population. Currently, indigenous females make up 2.5% of the Australian female population and they experience poorer health across all areas. It is thought that their health needs are not fully addressed and consequently the federal government aim to develop a new national women's health policy which will address cultural needs and previous experiences. There is also a difference in the way that indigenous women conceptualise illness and thus may not present as readily for medical treatment (Burns et al, 2010).

Neoplasms of the genital tract account for 17% of cancer deaths in the indigenous population. Incidence of cervical cancer and mortality has been declining in Australia for many years, however the incidence and mortality in indigenous women is considerably higher than national levels, which is thought to be due to indigenous women not participating in cervical screening. Cervical cancer affects 7% of indigenous women each year and is the fourth most common female cancer. In the UK, cervical cancer accounts for 2% of all female cancers and is the eleventh most common cancer in women (Cancer Research UK, 2010).

Indigenous women have babies at a younger age compared with the UK and the general Australian population. The median age was 24.7 years compared to 30.7 years in the general population. Indigenous women are 47% more likely to have postpartum haemorrhage (PPH) than women in the UK, as it is seen more commonly in younger mothers under the age of 25 years. The incidence of PPH in the UK is 3.3 per million maternities (Wee et al, 2004). Indigenous women also have higher fertility rates and are less likely to require assisted conception methods compared with the UK where increasing maternal age plays a part in reduced fertility.

Objective 2 - To compare and contrast the provision of health care in Australia for Mothers and Neonates with that provided in the UK.

Australian health care is primarily provided to Mothers and Neonates by a Government service called Medicare Australia. It was formerly known as the Health Insurance Commission, initially established to ensure the administration of a universal health insurance system. Medibank Private was established following government reforms in 1975 and then in 1984 Medicare Australia was introduced as the universal health care system. The Health Insurance Commission won the right to administer the system and discontinued its relationship with Medibank Private. Private insurance schemes still exist and Australian citizens can hold concurrent private health insurance as well as Medicare. Public hospitals encourage patients to use their private insurance policies where possible to help provide funds for the hospital (Medicare Australia, 2010).

Medicare Australia provides free treatment as a public patient in a public hospital. All gynaecological and obstetric operations are provided free of charge in a public hospital under this service, as is the case in the UK whereby the National Health Service (NHS) funds inpatient procedures. Admission to Neonatal Intensive Care Units is also funded by Medicare Australia as is Intensive Care treatment in the UK. As outpatient care is not fully funded by Medicare, practitioners use Bulk Billing as a method of payment for their services, such as ultrasound

scanning. Infertility treatment is heavily subsidised by Medicare and patients pay a small contribution towards it. Only one cycle of IVF is funded by the NHS in the UK.

Medicare Australia also offers free or subsidised treatment from general practitioners, optometrists, specialists and dentists. Medicare Australia is funded in a similar way to the NHS, whereby Australian citizens make contributions from their salaries in the same way that British citizens contribute to the NHS through National Insurance contributions. A reciprocal health agreement exists between Medicare and the NHS, which entitles a British citizen to Medicare benefits when in Australia and an Australian citizen to NHS treatment when in England, as long as they are eligible for treatment in their home countries.

Objective 3 - In Australia, how is the risk of preterm labour detected and managed and how does this compare with the UK?

In Australian teaching hospitals, cervical length measurement is utilised to detect the likelihood of preterm labour. This is thought to be superior to biochemical methods (Welsh and Nicolaides, 2002). It is measured in women who present with symptoms suggestive of preterm labour such as abdominal pain. The expectant mother is assessed for any organic causes of her abdominal pain such as a urinary tract infection and blood tests are taken. She is usually admitted for monitoring and following obstetric review, a transvaginal scan is carried out to measure cervical length. A short cervix increases the likelihood of preterm labour and if this is detected, it is either managed conservatively with the use of progesterone or surgically with cervical cerclage.

In Australian district general hospitals, fetal fibronectin is utilised as a biochemical marker to predict preterm labour and to assist with clinical decision making. The test has a high negative predictive value of 99.7% that the woman will not deliver within 14 days. With a negative result therefore, you are able to reassure the woman and send her home. A sample is obtained from cervico-vaginal secretions. A positive result is not particularly helpful as it is inconclusive. It suggests that 1 in 6 women will deliver within 14 days, which necessitates admission to hospital and would warrant tertiary transfer to a central teaching hospital where more specialist help can be sought (Honest et al, 2002).

I completed an audit on preterm labour in a central teaching hospital in London whereby fetal fibronectin was utilised. The value was certainly seen in the negative result of the test and we were able to discharge women home who were at very low risk of preterm labour, thus saving admission costs. However, it was less helpful when a positive result was obtained and consequently women were monitored overnight. Cervical length was not routinely measured unless surgical intervention was required. In Australian teaching hospitals, there is currently a move towards routinely measuring cervical length transvaginally at the 18-20 week fetal anomaly scan to determine the risk of preterm labour.

Objective 4 - Reflect on clinical encounters in the Department of Women and Babies and determine how these experiences will affect my future clinical practice.

During my clinical attachment in the Department of Women and Babies, I found that working in the Early Pregnancy Assessment Service (EPAS) was the most challenging as I was dealing with women who had suffered miscarriage. The diagnosis would be confirmed following an ultrasound scan to determine the viability of the fetus. I witnessed excellent communication skills especially related to breaking bad news and the importance of providing a silent period following the initial diagnosis to allow time to reflect on the news. I will certainly utilise these very useful techniques in

my clinical practice.

I have thoroughly enjoyed my experience of ultrasound and I was able to attempt to scan the pregnant abdomen. I found this to be quite challenging. My biggest difficulty was determining the orientation of the ultrasound probe but once I was given some careful guidance by my consultant, I felt more confident with the use of ultrasound. I certainly require further practice in this complex skill and this experience has stimulated my interest in postgraduate study in medical ultrasonography. I found that working on night shifts in an extremely busy Labour Ward both rewarding and challenging. I was able to witness several caesarean section deliveries, assisted with instrumental deliveries and helped the doctors with their ward jobs. I have learnt to prioritise tasks according to clinical need and I feel that this will be invaluable to me in my future career.

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