## ELECTIVE (SSC5c) REPORT (1200 words)

A report that addresses the above four objectives should be written below. Your Elective supervisor will assess this.

**1. What are the prevalent obstetric problems in East London? How do they differ from the rest of the UK?**

**Based on my experiences at the Royal London Hospital there are two main obstetric complications that I have observed to be prevalent in East London, these are gestational diabetes and induction of labour due to obstetric cholestasis.**

**I have researched obstetric problems in London compared to the rest of the UK and there are a number of differences in obstetric statistics:**

**Firstly it is noticed that London has a higher number of low birth weight babies when compared internationally1. There is a correlation between low birth weight babies and deprivation in London probably due to a number of maternal factors such as nutrition, poor housing and maternal smoking1.**

**East London also has a higher rate of preterm births, this also correlates with areas of deprivation1.**

**There are significant differences in intervention rates (e.g. assisted deliveries and caesarean section rates) in providers across London. London has the highest elective and emergency caesarean section rate in the country2. This could be due to a number of factors such as obstetric complications, are demographics and patient choice**

**On the whole, women in London are healthier than those in the rest of England and Wales, but there are large health inequalities within London, often reflecting socioeconomic factors such as deprivation and ethnicity3. This is an easy conclusion to make based on the ethnic diversity and huge differences in socioeconomic factors that can be seen throughout London.**

**When comparing obstetric complications and birthing statistics of London with the rest of the UK it is important to think about the demographics of the different areas4:**

- **There is an age difference in London in comparison with the rest of the UK in that more women in London (68%) are aged 30 or over than the rest of the country (60%). This could account for a higher incidence of complications related to increased maternal age.**

- **There is wide ethnic variation in London (66% Caucasian) compared to the rest of the UK (87% Caucasian). This may well account for certain genetic obstetric complications such as the higher rates of gestation diabetes which is much more common in women of an Asian background.**

- **There may also be a difficult language barrier in London with a lower rate of women speaking English (77%) than in the rest of the country (87%). This may lead to difficulties for these women in understanding and accessing the services available to them.**

**These factors can in part account for the large number of patients with gestational diabetes that I observed at the Royal London as there is a higher incidence in patients of Asian origin than in Caucasians. An explanation as to the high number of patients with Cholestasis of pregnancy could be the higher maternal age although the exact aetiology of this condition is unknown5.**

**When considering the higher proportion of Black and Minority Ethnic women in London it is important to note that a survey found twice as many ethnic minority women worried about factors such as pain and embarrassment during birth than Caucasian women6. This could be due to a number of factors such as understanding of information and antenatal support but is important to keep in mind when treating women in London.**

**2. How are the obstetric services ordered in East London? How does this differ from the rest of the UK?**

**They way in which obstetric services are ordered seem to differ throughout the UK and are dependent on the region and the trust offering the service.**

**In England women are offered NHS care for labour and birth at home, in a number of different centres including: obstetric units (OUs) in hospitals, free standing midwifery units (FMUs) which are in a different place as the OU and alongside midwifery units (AMUs) which are on the same site as OUs. There is a wide variation in the provision of different settings for births in England, by trust and by region7.**

**Antenatal care will differ throughout trusts but follows general NICE guidelines as to the timings of appointments and whether or not these appointments are with a midwife or a doctor. In London there is a higher proportion of patients who present later in pregnancy possibly due to a decreased awareness of services, ethnic variations in expectations of care or language barriers.**

**The main differences between the services in London and the rest of the UK seem to be that women in London feel they are given less choice with regards as to where they can give birth.**

**Coupled with this, medical interventions during birth in an OU setting continue to increase which may explain why there is a larger number of interventions in London than in the rest of the UK4. However, this may also be due to the highly specialised nature of the hospitals in London which many women may travel to in order to receive the best care.**

**3. To research the Royal College of Obstetricians and Gynaecologists Global Health Strategy (2013-2017) and gain an understanding into the effects of this program throughout the world.**

**The Royal College of Obstetricians and Gynaecologists Global Health Strategy (2013-2017) has six aims8:**

**i) To ensure outstanding professionalism in all matters affecting the provision of quality health care for women.**

**ii) To promote global advocacy for women's health and childbirth.**

**iii) To establish access to trained specialists ensuring high-quality care for women at all times.**

**iv) To enhance evidence-based practice to ensure the highest quality of care.**

**v) To keep standard-setting and education provision at the core of all RCOG work.**

**vi) To develop leadership, both managerial and clinical, within all aspects of the profession.**

**The Health Strategy has been implemented throughout the world, the key areas of current activity include Africa, South Asia and Eastern Europe. Where there are a number of courses including life saving skills and specialist workshops to help improve good quality health care8.**

**The goals of this Global Health Strategy are dignified with the hope of providing better health care for women and developing clinical standards whilst advocating women's and girls' health and human rights. As a charity needing to raise the funds for this project it is amazing the amount that has been done to help to date. With the Global Maternity Mortality Ratio decreasing from 320 per 100.00 live births in 1990 to 251 per 100,000 births in 2008 the effects of this program so far are clear to see and there is every hope that this will continue to decrease in the future8.**

**4. To gain more experience of a specialism that I am interested in. To be part of and Obstetric and Gynaecology team in a busy and specialised London Hospital. To complete a piece of work or be part of an audit in Obstetrics and Gynaecology. To complete a reflection on my elective experiences.**

**Throughout my six week Obstetric and Gynaecology placement at the Royal London Hospital I feel I have gained an insight into what it is like to work in a busy, specialised hospital within this speciality. I have been part of a number of interesting cases that have helped me to gain a better understanding of the speciality and I have thoroughly enjoyed my time here. As the Royal London is a specialised hospital with the low risk births being dealt with in a midwife led unit at a different site my main experience has been with high risk pregnancies. There are a number of cases that I would like to briefly reflect on from my time here.**

**The first was a lovely patient who was pregnant with twins, she sadly went into premature labour (at 22 weeks) and in the space of two weeks lost both twins. I found her case understandably very emotive and upsetting, I could only imagine the difficulties she would have to face dealing with her loss. This case gave me a stark insight into the difficulties faced by Obstetricians and patients in dealing with neonatal death and I can only hope to be as sympathetic and caring as the doctors and midwives have been that were involved in this case.**

**The second case was of placenta accreta, although I wasn't involved in this case myself I was in theatre with the registrar when she was called to an obstetric haemorrhage. I thus witnessed the response to an emergency and understand how difficult it is to be called to an emergency when you are scrubbed in theatre, having to assess the risks of each case and decide where you can be of more use as a doctor. It also made me aware of the support that you get from other members of your team especially in an emergency situation.**

**I have really enjoyed my six weeks of elective and feel privileged to have been part of a number of births during my time at the Royal London. This placement has helped me to gain more experience of a speciality that I am interested in and hope to join in the future.**

**References**

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**2. Healthcare Commission. Towards Better Births: A Review of Maternity Services in England. Commission for Healthcare Audit and Inspection, London, 2008. [Online] Available from:**

**http://webarchive.nationalarchives.gov.uk/20101014074803/http:/www.cqc.org.uk/_db/_documents/Towards_better_births_200807221338.pdf [Accessed 16/05/2015].**

**3. Greater London Authority. Women in London: Capitalwoman, 2008. [Online] Available from: http://www.london.gov.uk/sites/default/files/archives/gla-publications-women-WomeninLondoncapitalwoman2008.pdf [Accessed 16/05/2015].**

**4. Review of maternity services. London: Healthcare Commission, 2007. [Online] Available from: http://www.nhssurveys.org/Filestore/CQC/2007_Maternity_services_survey_report.pdf [Accessed 17/05/2015].**

**5. Royal College of Obstetricians and Gynaecologists. Green-top Guideline Number 43. Obstetric Cholestasis, 2011. [Online] Available from: https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg43/**

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**6. Redshaw, M. and Heikklia, K. (2011) Ethnic Differences in Women's Worries about Labour and Birth. Ethnicity and Health. 16(3): 213-223.**

**7. Healthcare for London. A Framework for Action, 2011. [Online] Available from:**

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**8. Royal College of Obstetricians and Gynaecologists. Global Health Strategy, 2013-2017. [Online] Available from:**

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