A short history of O&G in Cardiff

Alison Fiander
Welsh Obstetrics & Gynaecology Society
March 2015
History of Medical School

• Preclinical BSc in Cardiff since 1893
  – Chairs in Anatomy & Physiology
  – Lecturer in Pharmacology
• Clinical in London - UCH, St Mary’s
• Welsh National School of Medicine 1932
  – based at Cardiff Royal Infirmary (CRI)
  – responsible for clinical training
Cardiff Royal Infirmary
History of Medical School

• Teaching space a problem at CRI
• Heath Estate of 200 acres found in 1950 & purchased for £42,400
• Dental Hospital and School opened 1966
• 800 bed University Hospital of Wales and WNSM opened by Queen 1971
• 1973 Obs & Gynae at UHW
University Hospital of Wales
Heath Site
History of Obstetrics & Gynaecology in Cardiff

- Site of delivery dependent on side of Taff river
- Glossop Terrace opposite CRI if east of river
History of Obstetrics & Gynaecology in Cardiff

- St David’s hospital if west of river
- St David’s originated as a workhouse in 1830 and delivered midwifery care as poor law hospital until 1930
- Cardiff council assumed responsibility until NHS in 1948
St David’s hospital maternity unit
History of Obstetrics & Gynaecology in Cardiff

• Glossop Terrace moved to UHW - 1973
• St David’s moved to Llandough hospital - 1990
• 2 units split by river Taff, 3000 deliveries/yr
• 2 neonatal units
History of Obstetrics & Gynaecology in Cardiff

- UHW NHS Trust and Vale & Community NHS trust merged 1999
- Neonatal services withdrawn from Llandough
- Women’s Service Review:
  - Women’s Unit at UHW delivering >6000/yr from 2005
  - Gynaecology services at Llandough until 2013
History of Academic Obs & Gynae in Cardiff

Professors of Obstetrics & Gynaecology:

• Sir Ewen Maclean 1921-1931
• Gilbert Strachan 1932-1953
• Archibald Duncan 1953-1966
• Sir Alexander Turnbull 1966-73
• Bryan Hibbard 1973-1991
• Robert Shaw 1991-2001
• Alison Fiander 2002-2015
Maternal and perinatal health in Wales

- Poor access to health services in mining valleys
- Poverty
- High maternal mortality
- High perinatal mortality
- > 30% home births
4th Confidential Enquiry 1961-3

Cause of death:

- Abortion 139
  - all associated with avoidable factors, 77 procured
- Pulmonary embolism 129
- Pre-eclampsia 104
- Haemorrhage 92

Caesarean section rate 3.2% (E&W)
1.5 deaths per 1000 CS
<table>
<thead>
<tr>
<th>MMR per 100,000 births</th>
<th>1961-3</th>
<th>1970-2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newcastle</td>
<td>28.3</td>
<td>13.2</td>
</tr>
<tr>
<td>Leeds</td>
<td>30.8</td>
<td>17.2</td>
</tr>
<tr>
<td>Sheffield</td>
<td>30.7</td>
<td>12.7</td>
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<tr>
<td>East Anglia</td>
<td>36.2</td>
<td>13.2</td>
</tr>
<tr>
<td>NW Metropolitan</td>
<td>36.1</td>
<td>13.7</td>
</tr>
<tr>
<td>NE Metropolitan</td>
<td>42.3</td>
<td>16.0</td>
</tr>
<tr>
<td>SE Metropolitan</td>
<td>30.9</td>
<td>12.7</td>
</tr>
<tr>
<td>SW Metropolitan</td>
<td>28.5</td>
<td>13.9</td>
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<tr>
<td>Wessex</td>
<td>23.3</td>
<td>9.7</td>
</tr>
<tr>
<td>Oxford</td>
<td>21.3</td>
<td>5.9</td>
</tr>
<tr>
<td>S Western</td>
<td>22.4</td>
<td>11.4</td>
</tr>
<tr>
<td>Birmingham</td>
<td>35.9</td>
<td>15.3</td>
</tr>
<tr>
<td>Manchester</td>
<td>34.6</td>
<td>12.6</td>
</tr>
<tr>
<td>Liverpool</td>
<td>30.1</td>
<td>11.6</td>
</tr>
<tr>
<td><strong>Wales</strong></td>
<td><strong>36.3</strong></td>
<td><strong>8.6</strong></td>
</tr>
<tr>
<td><strong>England and Wales</strong></td>
<td><strong>32.0</strong></td>
<td><strong>12.9</strong></td>
</tr>
</tbody>
</table>
Sir Ewen Maclean 1865-1953

- Born in Carmarthen, S Wales
- Graduated from Edinburgh MB, CM 1889
- Appointed O&G Cardiff Royal Infirmary 1901
- Served in RAMC in WW1
- Chair O&G on creation of WNSM 1921-31
Sir Ewen Maclean 1865-1953

• Involved in formation of BCOG
  – President 1935-8

• Published on
  – *Encyclopaedia of midwifery & diseases of women*
  – Tuberculous infection of the female genitalia
  – Puerperal sepsis & maternal mortality

• Knighted in 1923

• JP for Cardiff
Gilbert Innes Strachan 1888-1963

• Born and educated in Glasgow, MB ChB 1910
• Captain in RAMC in WW1
• Research pathologist MRC after war
  – Morbid anatomy of placenta & stillbirth
• Lecturer in Midwifery, S Wales, 1921
• Chair O&G 1932 WNSM
• Foundation member of RCOG 1929
  – Fellow 1931, member of council 3 times, VP 1952-5
  – FRCP 1931, FRCS (England & Edinburgh) 1921
Gilbert Innes Strachan 1888-1963

- Keen supporter of BMA, MDU
- *Textbook of Obstetrics* published in 1947
- Studied use of radium for cervical cancer
- Awarded CBE 1953
- Married, one son
- Interested in antiques especially china
- Great energy, prolific writer, fluent speaker
Archibald Sutherland Duncan 1914-1992

• Born in Darjeeling, India, son of Church of Scotland missionaries
• Graduated from Edinburgh 1936 & trained in O&G
• Served 1941-5 as RNVR medical officer
  – Awarded Distinguished Service Cross for rescuing casualties from sinking destroyer in Mediterranean
Archie Duncan 1914-1992

- Appointed Chair O&G in Cardiff 1953
  - Concerned by excess perinatal mortality in Wales
- Suffered MI whilst Professor in Cardiff
- Returned to Edinburgh as Dean and Professor of medical education
- Key role in setting up Institute of Medical Ethics
  - Founding editor Journal of Medical Ethics
Alexander Cuthbert Turnbull 1925-1990

• Born & graduated from Aberdeen MB ChB 1947
• National service in Malaysia and India
• Senior Lecturer in O&G Dundee and Aberdeen
• Chair O&G WNSM 1966-73
• Moved to Oxford 1973
Alexander Turnbull 1925-1990

• Research on IOL using oxytocin
  – Developed the Cardiff pump
  – Women induced at 38 weeks
  – Appointed J Pearson to investigate fetal monitoring
  – Cardiff Kick Chart developed

• In Oxford investigated
  – Initiation of parturition
  – Mechanism & aetiology of preterm labour
  – Serum screening for spina bifida
  – Development of IVF
  – Mechanisms of DUB
Alexander Turnbull 1925-1990

• Contributor to triennial reports
• Advisor to CMO
• Many honorary titles and fellowships
• Eardley Hollard Medal RCOG 1990
• Married to doctor
• CBE 1982, knighted 1988
Subsequent chairs of Obstetrics & Gynaecology

• Bryan Hibbard 1973-1991
• Robert Shaw 1991-2001
• Alison Fiander 2002-2015
What next for Academic O&G in Wales?

• School of Medicine reorganization entitled “Medic: the way forward”
  – Chairs in medical education and research areas, rather than specialty chairs
  – Disinvestment in Gynaecological Oncology
  – Some support for Global (Women’s) Health
  – How to attract PG into specialty in Wales?
State of Global Women’s Health
&
RCOG Leading Safe Choices programme

Alison Fiander
Welsh Obstetrics & Gynaecology Society
March 2015
Maternal mortality

‘To be pregnant in Africa is to have one foot in the grave’

- 289,000 women die in pregnancy annually
- 800 deaths every day
- 95% in SSA and Asia
- MDG5 – are we making progress?
  – Yes, but more work to do
Maternal mortality

• Half the deaths occur in 6 countries
  – Afghanistan, India, DRC, Ethiopia, Nigeria, Pakistan

• 5 countries have MMR >1000
  – Afghanistan, Malawi, CAR, Sierra Leone, Chad

• Very high cumulative risks
Lifetime risk of maternal death

- Developed regions: 1 in 7,300
- Sweden: 1 in 17,400
- Asia: 1 in 94
- Sub-Saharan Africa: 1 in 22
- Chad: 1 in 8
- Sierra Leone 1 in 7
Risk of dying in childbirth
Causes of maternal deaths

5 big killers (75% of deaths):
• Haemorrhage
• Sepsis
• Hypertensive disorders
• Abortion
• Obstructed labour

• Indirect
  – malaria, anaemia, HIV
Maternal mortality

• High contribution by unsafe abortion
  – 8 deaths/hour due to unsafe abortion
• Unmet need for family planning
Causes of maternal deaths

- Haemorrhage 24%
- Sepsis 15%
- Hypertensive disease 12%
- Obstructed labour 8%
- Abortion 13%
- Other direct causes 8%
- Indirect causes 20%
Obstacles to safe motherhood

3 major delays:
Obstacles to safe motherhood

• Delay in deciding to seek care
  – Non recognition of danger signs
  – Lack of preparation by family & community
Obstacles to safe motherhood

• Delay in reaching health care facility
  – Poor roads, lack of transport, poor communication
Obstacles to safe motherhood

- Delay in appropriate care after reaching facility
  - Inadequate skilled staff
  - No access to caesarean section
  - Lack of drugs, equipment, supplies
  - Poor referral system
Mortality

Morbidity
Injury & disability from childbirth

For every death, 30 women suffer severe injury or disability eg obstetric fistulae
What is VVF?

A hole between the Vagina and Bladder (VVF)
The Obstetric Fistula injury complex

Primary damage

• Genital tract fistula
  – Bladder, Urethra, Uterus, Rectum
• Nerve damage
• Pelvic Floor Muscle damage
The Obstetric Fistula injury complex

Secondary damage
• Social outcast, Depression, Suicide
• Malnutrition
• Foot Drop, Contractures, Deformity
• Bladder stones, Renal damage
• Dermatitis
• Infertility
The cause of VVF: unrelieved obstructed labour

Urban poverty, lack of free medical care, overcrowded hospitals

Remote dwellings, no transport, lack of health facilities/hospitals for C/S
Vesico-Vaginal Fistula is

More than a **hole** in the bladder

The **whole** body is damaged
Vesico-vaginal fistula (VVFs)

Incontinence

Scarring, damage to pelvis

Infertility

Depression & suicide
Root cause analysis

• Status of women
  – Second class citizens
  – Neglect & apathy
  – Women die because they do not count
  – Society has yet to decide that women’s health is worthwhile

• Lack of Education

• Poverty
  – Independent income
“Women are not dying of diseases we cannot treat. They are dying because societies have yet to decide that their lives are worth saving”.

Professor Mahmoud Fatallah
Maternal Health: Global Scale of Problem

- 200 million pregnancies per year
- 75 million *unwanted* pregnancies
- 50 million induced abortions
- 20 million unsafe abortions
- 289,000 maternal deaths
  -(25% adolescents)
Every woman’s right: access to family planning

• Unmet need for family planning affects 222 million women (Guttmacher Institute & UNFPA)
  – Need greatest where maternal mortality highest: adolescents, migrants, *urban* slum dwellers, refugees, *women in the postpartum period*

• Every £1 spent on FP saves £11 treating pregnancy complications
  – FP makes economic sense
How important is contraception?

• Family planning saves lives

• Unplanned pregnancy
  – top killer of 15-19 yr old girls
  – 70,000 teenage deaths / year
  – 1 million babies born to adolescents die in 1st year

• Satisfying the global unmet need for contraception could reduce maternal deaths an additional 30 percent
Unmet need for family planning
“I asked: ‘Why doesn’t somebody do something?’

Then I realized I was somebody.”

Youth advocate
So what?

• What is the RCOG doing about women’s health globally?
• What am I doing about women’s health globally?

• RCOG programme: ‘Leading Safe Choices’
• 3 year pilot in Tanzania and South Africa
Advocacy for Women’s Health

• The purpose of advocacy is to change minds and persuade people to act differently

• 90% of the 287,000 maternal deaths this year are avoidable:
  – not with Western standards of health care but with measures that lie within the fiscal resources of the societies in which they live

• To avoid these deaths we need to educate health care providers to act differently
RCOG initiative on promoting best practices in postpartum contraception and safer abortion care

• For women to achieve their potential in society, they must have control over their own fertility and the freedom to plan and space their pregnancies.

• We need to use every healthcare encounter to promote and provide contraceptive services and adopt new technologies for safer abortion care.

• O&G’s are ideally positioned to improve the provision of family planning and safe abortion services, but many health care professionals regard these services as low priority.
### RCOG initiative ‘Leading Safe Choices’

<table>
<thead>
<tr>
<th>Project locations</th>
<th>Selected maternity hospitals in South Africa and Tanzania</th>
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</thead>
<tbody>
<tr>
<td>Duration</td>
<td>Phase 1: January 2015 – December 2017</td>
</tr>
<tr>
<td>Donor</td>
<td>Anonymous</td>
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<tr>
<td>Budget</td>
<td>9.7m USD</td>
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With two women to a bed, the maternity wards struggle to respect the patient’s right to safety, privacy and dignity.
Within busy urban hospitals how do HCP ensure access to contraception?
With limited resources, hospitals struggle to achieve basic standards of dignity & respect for pregnant women.
Access to services

• In rural areas access to health facilities is difficult
• The staffing gap means there are too few doctors, midwives and nurses, especially in rural areas
Rural access to health services
Waiting for baby

This young woman travelled for 3 days on foot to reach a maternity waiting home

She will wait with her 2 other children for the baby to arrive and then walk home again

Opportunity for health education, post partum FP, etc
Missed Opportunities

The birth of her baby was the only time she has seen a health care professional.

Every woman should be offered post delivery contraception so that she can decide when she next becomes pregnant.
A young girl wearing a school uniform dies in the hospital after an unsafe abortion  (Tanzania Nov ’14)
1 in 4 married women have unmet need for contraception

16% maternal deaths due to complications of unsafe abortion

60% of women hospitalized for “miscarriage” have had an unsafe induced abortion

Women report that a mid-level provider or doctor assistant performed their unsafe abortion

Guttmacher Institute - Unsafe abortion in Tanzania, 2013
Despite the progressive abortion law fewer than 50% of the public-sector health facilities are actually providing abortion services.

Conscientious objection is used extensively - security guards send women away.

Implants and pills less effective in HIV positive women taking ARV drugs.

Ipas News 2013: Is the door to safe abortion services slowly closing in South Africa?
RCOG: ‘Leading Safe Choices’

The Goal
To strengthen the competence and raise the standing of family planning professionals, including O&Gs, midwives, nurses and general practitioners by promoting best practices in post-partum contraception and comprehensive abortion and post-abortion care.
**RCOG programme: ‘Leading Safe Choices’**

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<td><strong>A three pronged approach</strong></td>
<td>• Promoting best practice in postpartum contraception and post-abortion care services</td>
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<tr>
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<td>• Translating best practice into professional competence</td>
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<td>• Professionalizing the practice of family planning &amp; post-abortion care services</td>
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</table>
A three pronged approach

Evidence:
• Promoting best practices in postpartum contraception and post-abortion care services (best practice papers)

Competence:
• Translating best practices into professional competence (training manuals and courses)

Excellence:
• Professionalizing the practice of family planning & post-abortion care services (formal certification process for HCP to recognize competence & raise their standing within the profession)
Meet the team(s)

**RCOG, UK**
- RCOG VP for Strategic Development
- Lesley Regan

**Clinical Lead**
- Alison Fiander

**Director of Development**
- Ann Tate
- & RCOG Global Health Unit

**Programme management team**

**International Experts**
- RCOG Expert Groups (Anna Glasier) for Best Practice Papers and Training
- in collaboration with
- UK Faculty of Sexual and Reproductive Healthcare (FSRH)

**Country Level** (SA & TZ)
- National Steering Group
  - including Ministries of Health and representatives from teaching hospitals

**National Programme Management team**

**Health Facility Level**
- Senior Facility Coordinators & Data Collectors from participating facilities
“The right to health is a human right: and the health of a nation is determined by the health of its girls and women.”

Flavio Bustreo - WHO
Thank you for listening
The RCOG Essential Gynaecological Skills (EGS) course
Introduction to EGS

Rationale

• Several training courses on emergency obstetric and newborn care
• Gynaecological conditions impose large burden of disease and lower quality of life in many LRC but have received little attention
• Low cost, effective or preventative solutions available
Goals

• To reduce maternal mortality
  – by avoiding unplanned pregnancy
  – effective management of gynaecological emergencies, eg ectopic pregnancy, complications of abortion
Goals

• To reduce *morbidity* by appropriate prevention or management of:
  – infection
  – urogynaecological conditions, including OF
  – menstrual dysfunction
  – cervical cancer
  – infertility

• To introduce concept of clinical governance and respectful gynaecological care
The EGS course

• A 3-4 day modular CPD course for non-specialist healthcare providers in LRC
• Non-specialist: nurses, clinical officers, AMO’s, medical officers, UG?
• Evidence-based focusing on common problems with available interventions
• Modular (flexible) structure
• Practical skills training
• Flexible complexity?
• Accompanying delegate & facilitator manuals
The EGS course

• Modeled on successful Life Saving Skills (LSS) RCOG/LSTM course
• ‘Train the trainers’ approach for scale up and sustainability
• Pilot courses
  – Use resources (AVA’s) already available if possible
• Application for funding
  – Develop resources where necessary
Structure of modules

• Short lecture
• AVA’s
• 4 breakout practical skills stations
• Small group work
• Additional material in course manual
• Ideal course size 24-32 participants
  – Each group containing 6-8 participants
Assessment

• Pre and post course knowledge based assessment
• Skills based testing?
• Work based assessment and mentoring?
Progress to date

10 draft modules:

- Basic history & examination
- Contraception
- Emergency gynaecology
- STI’s and HIV
- Menstrual dysfunction
- Early pregnancy loss
- ‘Working Smarter’: audit and clinical governance
- Urogynaecology
- Infertility
- Cervical cancer
Next steps

• Edit draft modules and feedback to authors
• Identify supporting materials eg AVA’s
• Final draft of delegate and trainer manuals
• Procure equipment
• Pilot course
• Apply for funding