

Truth and transparency in reproductive health



Ruth Armstrong
Senior Deputy Editor
mja@mja.com.au

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As a medical journal, we aspire to some high ideals, which translate roughly to truth (What are the best and most accurate data available about health?) and transparency (How confident can readers be that the data provided represent at least part of the truth?). Articles in this issue of the *MJA* aim to bring some truth and transparency to several incompletely understood aspects of reproductive health.

Although Australian perinatal mortality rates have more than halved over the past 40 years, the fetal component — the rate of stillbirth — has not changed much. Stillbirth is an emotive issue, and rightly so. In his book *A grief observed* (London: Faber & Faber, 1961), C S Lewis explored the unique nature of the grief of late pregnancy loss: "Never, in any place or time, will she have her son on her knees, or bathe him, or tell him a story, or plan for his future, or see her grandchild".

In recent years, stillbirth has come "out of the shadows" in terms of the subjective, human experience, but we still lack data on many of the medical, socioeconomic and other contributors to stillbirth, and how it might be prevented. A study by Drysdale and colleagues (*page 278*) brings a small slice of "truth" to this problem. The authors examined the connections between ethnicity and stillbirth in a metropolitan maternity service in Melbourne. About one in seven women in their large sample was born in South Asia (India, Sri Lanka, Bangladesh or Pakistan), and these women were 2.4 times more likely to have a late-pregnancy antepartum stillbirth (3.55 per 1000 births) than women born in Australia.

According to Flenady and Ellwood (*page 256*), the drivers of this disparity will remain unclear until we have better investigation of the causes of individual stillbirths, and accurate, standardised reporting of perinatal statistics. A recent report card finds we have improved in this regard, but could do better (<http://www.aihw.gov.au/publication-detail/?id=10737422546>).

Fertility treatment is mostly a "good news" issue, but a South Australian study published earlier this year, showing an excess of birth defects in babies born after fertility treatment (*N Engl J Med* 2012; 366: 1803-1813), caused widespread concern. In this issue, Davies and Haan (*page 259*), two of the study's authors, discuss how having good data on the small but significantly increased risk associated with some patients and procedures will help clinicians make decisions about individual patients. Bringing transparency into our evaluation of established techniques in this way can only enhance their safety and efficacy.

Medical abortion with mifepristone and misoprostol has had a controversial history in Australia, as outlined by de Costa and Carrette (*page 257*). Although available to individual doctors who apply to import and administer it, and endorsed for medical abortion by the Royal College of Obstetricians and Gynaecologists, mifepristone has no commercial sponsor in Australia, and no official Therapeutic Goods Administration approval. Goldstone and colleagues (*page 282*) describe the outcomes of medical abortion for more than 13 000 women at Marie Stopes International Australia clinics over a 2-year period. This is an important study for those weighing up the safety and efficacy of medical abortion, and underscores the importance of having consistent best-practice protocols, full follow-up and accurate data for the large group of women who choose this option.

Stillbirth, fertility, abortion. What more emotive and controversial topics could the Journal choose to explore? We would argue that, aside from ethical issues and the profound psychological impact of these events, providing data and informed commentary in these areas reflects the core business of a medical journal — to bring truth and transparency to matters that affect our lives and our health.

Marge Overs
MJA News and
Careers Editor
movers@mja.com.au



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A new generation

Obstetrics and gynaecology is changing: women now make up 80% of the training cohort in Australia, and the after-hours component of obstetrics, an issue that may have deterred many women from the specialty, is also lessening. In Career Overview (*page C1*), we look at the changing face — and changing faces — of obstetrics and gynaecology, and provide a few tips on how to get a foot in the door of this competitive specialty. In Medical Mentor (*page C5*), we profile obstetrician and

gynaecologist Professor Alastair MacLennan, whose career has spanned 45 years. Road Less Travelled (*page C6*) reveals the double life of cancer researcher Professor Graham Mann, who unravels the genetic code of melanoma in his day job and sings with the popular and eccentric men's choir, the Spooky Men's Chorale, after hours. Money and Practice (*page C7*) looks at the need for doctors to have their own general practitioner and the increasing focus on ensuring doctors have the skills to treat their colleagues.