SOGC hosts 21st International CME in Guatemala

Physician survey reveals regional disparities in care across Canada

The clock is ticking on Canada’s obstetrical HR shortage

International Women’s Health Program begins new project in Guyana
I would like to thank all of those individuals who offered their time and patience and took part in the SOGC Health Human Resource Survey. I realize that, as health professionals, we are often asked for our input on one survey or another, so we greatly appreciate your time in helping us collect this crucial data. I am pleased to announce that over half of the approximately 1750 ob/gyn professionals in Canada have taken part in this endeavor. This is important, as a high response rate helps ensure the accuracy and credibility of our results. This will be particularly important in future stages, when we will present our results to governments, key stakeholders and policymakers.

These results will impact on the future of our profession, influencing important decisions, including: the number of residents in each program; the remuneration of our members; the possibility of mixed remuneration; and the development and implementation of collaborative practice models in various areas of Canada. Thanks to your help, these results will provide important insights to aid work force planning of our specialty for the next decade.

I would like also to thank those of you who provided feedback about the implementation of this survey. Many of you told us that you receive many surveys, and taking the time to respond to them all can be cumbersome. As a result, for any surveys we undertake in future years, we will do our best to focus on making the process as convenient as possible for all.

Again, I thank you all for your participation and time in this important work. I look forward to sharing the results with you all soon.

NEW RESOURCES

Introduction of HPV Vaccination spurs discussion of “ob/gyn as vaccinator”

With the introduction of the Human Papillomavirus vaccine in Canada in 2006, ob/gyns are acquiring new expertise in the administration of vaccines. In an editorial in the March-April issue of the ACOG Clinical Review, Dr. Stanley A. Gall discusses the issue of how the introduction of the HPV vaccine has opened doors for ob/gyns to begin to administer additional vaccination services.

“Because most ob-gyns are now administering the HPV vaccine, it is appropriate to expand this newly acquired expertise to other important vaccines, which our Fellows can and should be administering on a routine basis in their offices and clinics,” writes Dr. Gall in the editorial.

Dr. Gall further lists the vaccines that are among the most likely candidates for administration by ob/gyns, including influenza, hepatitis B, tetanus-diphtheria-acellular pertussis (Tdap), pneumococcal, herpes zoster, and meningococcal vaccines.

“If your office work flow is set up to administer the HPV vaccine, providing additional vaccines would be an extra benefit for your patients and your practice,” writes Dr. Gall in the editorial.

To read Dr. Gall’s complete editorial, please consult the ACOG Clinical Review, Volume 13, Issue 2 (March-April 2008).

OBITUARY

Dr. Harry Oxorn

It is with deep regret that the SOGC announces the passing of Dr. Harry Oxorn on March 16th. He was 87. Throughout his distinguished career, Dr. Oxorn has served as head of ob/gyn at Reddy Memorial and Ottawa Civic hospitals, and was a respected professor at the University of Ottawa. In 2003, he was presented with the distinguished honour of being named to the Order of Canada for his contributions to medicine. Dr. Oxorn was also an active member of the SOGC, and in 1994, he was presented the SOGC’s President’s Award – the highest award given by our society – for his commitment and achievement in the specialty. Dr. Oxorn also authored the book chronicling the SOGC’s history, titled SOGC: the First Fifty Years, 1944-1994.

On behalf of the entire SOGC, and the many students, patients and colleagues whose lives and education Dr. Oxorn has enriched, we wish to offer our sincerest condolences to the Oxorn family.

CORRECTION

The 2008 SOGC Desk Calendar, distributed to SOGC Members, includes a small error relating to the 20th Quebec CME, which will be hosted Oct. 2-4 at the Fairmont Tremblant hotel in Mont Tremblant, Quebec. On the entries for the dates Oct. 2nd, 3rd, and 4th, the calendar incorrectly lists the event as being hosted in Quebec City. (The SOGC apologizes for any confusion this may cause.)
The clock is ticking on Canada’s obstetrical HR shortage… and still we wait for the federal government to make maternity care a priority.

For the past 18 months SOGC has been working hard to put the spotlight on maternity care in Canada and the urgent need for the federal government to take a leadership role to ensure that Canadian women and their babies have access to the care they need during pregnancy and child birth.

SOGC developed A National Birthing Initiative for Canada as a follow up to the Multidisciplinary Collaborative Primary Maternity Care Project. The Initiative contains seven action items – everything from models of care, to data gathering, to education of maternity care providers. Along with our partners (family & rural physicians, nurses and midwives), we have aggressively pursued government to recognize the concerns.

No one, that is, except those of us on the front line of maternity care in Canada. Our advocacy efforts have been well-received. SOGC has met with the Minister of Health; the Chair and key members of the Parliamentary Health Committee; the Conservative Health Caucus; the Health critics from the Opposition parties represented in the House of Commons; plus other Senators and MPs; as well as staffers who have taken a keen interest in the National Birthing Initiative. We see interest and enthusiasm; but from the Minister, we have yet to see commitment.

During our meetings we have also been urging government to commit funding to An Aboriginal Birthing Initiative for Canada. The federal government has a clear responsibility to act on behalf of Aboriginal peoples. Recent tragic events in First Nations’ communities confirm that solutions to many of these social and health challenges begin at the very beginning, when a new member of a family (and a community) are born and nurtured from the very first breath in their home communities. Returning birth to rural, remote and Aboriginal communities is a core element of both the Aboriginal and mainstream birthing initiatives; our proposal suggests innovative ways that, working together in a true multidisciplinary practice model, we can make that happen.

SOGC’s advocacy efforts will become even more persuasive with the release of the results of our HHR survey expected later this year. With a majority of Canada’s obstetricians responding, it is clear that cracks in the system are reaching breaking point, and that the current situation is potentially dangerous and cannot be sustained. Obstetricians overwhelmingly report “burn-out”, with relentless call schedules and patient loads demanding well beyond what could be called a reasonable workload. And without exception the moms and babies are cited as their greatest concern. Soon, best efforts and personal sacrifices will not be enough to ensure a safe and healthy pregnancy and birth for every Canadian mother and child.

We cannot let this happen. SOGC will continue to push the federal government to invest in maternity care in Canada. Adding your voice will make our case more compelling. If you are willing to get actively involved, please contact Nancy Bickford (nbickford@sogc.com); Nancy can provide you with information on how you can make a difference.
Upcoming Meetings

SOGC Meetings

4th Ontario Gynaecology CME
April 18–19, Toronto, Ontario

64th Annual Clinical Meeting
June 25–29, Calgary, Alberta

20th Quebec CME
October 2–4, Mont-Tremblant, Quebec

4th Quebec Obstetrics CME
November 13–14, Montreal, Quebec

27th Ontario CME
December 4–6, Toronto, Ontario

Program Schedule

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<tr>
<th>Location</th>
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<tr>
<td>Toronto, ON</td>
<td>April 20–21, 2008</td>
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<td>(in conjunction with the 4th GYN CME)</td>
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<tr>
<td>Montreal, QC</td>
<td>May 11–12, 2008</td>
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<tr>
<td>Calgary, AB</td>
<td>June 23–24, 2008</td>
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Other Meetings

2008 CME Congress, May 29 – 31, 2008. The Hyatt Regency Hotel. Vancouver, BC. For more information, visit www.cmecongress.org or email info@cpdkt.ubc.ca.

18th World Congress on Ultrasound in Obstetrics and Gynecology, 24-28 August, 2008, at the Navy Pier, Chicago, USA. Abstract submission open online until February 24th only. To submit abstracts, register or to find out more visit www.isuog.org. For inquiries, email congress@isuog.org.

Seventh International Scientific Meeting - Royal College of Obstetricians and Gynaecologists (in conjunction with SOGC and ACOG), September 17-20, 2008, Fairmont Queen Elizabeth Hotel. Montreal, Canada. For complete details visit www.rcog2008.com

8th Annual General Meeting – Canadian Association of Midwives, November 12-14, 2008, Delta Hotel, Québec, QC. For complete details visit www.canadianmidwives.org.

October 2–4, 2008
Program offered in French

In Collaboration with the « Association des obstétriciens et gynécologues du Québec (AOGQ) »
64th Annual Clinical Meeting

June 25–29
2008
Calgary, Alberta
TELUS Convention Centre

The Society of Obstetricians and Gynaecologists of Canada

Register ON-LINE at: www.sogc.org

This program is offered in English with French simultaneous translation for the International Symposia.


Conference Site: The Annual Clinical Meeting will be held at the TELUS Convention Centre.

Accommodations:
Marriott Calgary, 110 9th Avenue, SE, Calgary
Note: The Marriott is attached to the TELUS Convention Centre.
Standard Room: $199 single/double occupancy;
Reserve before Friday, May 16, 2008
Tel.: (403) 266-7331 or 1-800-896-6878
Group Code: SOGC

The Fairmont Palliser, 133 9th Avenue, SW, Calgary
Note: The Palliser is connected to the TELUS Convention Centre by an above ground, covered walkway.
Fairmont Room: $199 single/double occupancy;
Reserve before Friday, May 16, 2008
Tel.: (403) 260-1230 or 1-800-441-1414
Group Code: SOGCC

www.sogc.org

Photos provided courtesy of Tourism Calgary.
Members’ Corner

PROMOTING WOMEN’S HEALTH: Women’s health education and the Phila Project
By Geneviève Bouchard-Fortier
Medical Student Representative of the Junior Member Committee

Health education and disease prevention are increasingly important in the practice of medicine at every level. This was the motivation for Dr. Suzanne Morin, a general internist at McGill University with expertise in women’s health and education, to develop a health education program for young women. Over a period of six months, the Phila project was created. Named for a Hutu word meaning “be well”, the innovative new project promotes healthy life choices, and aims to increase awareness of chronic diseases and validate knowledge about sexual health issues such as contraception, sexually transmitted infections and HPV vaccination. We also intended to increase awareness of health problems faced by adolescents in developing countries.

The project is delivered by a team, put together by Dr. Morin, which includes a pediatrician, a yoga instructor and two medical students. I had the privilege of participating as one of the medical students. This novel project was presented for the first time last summer, to a group of teenaged women who participated in the Counsellor in Training program of a summer camp north of Montreal. The camp setting offered an ideal environment, conducive to learning and sharing. This was particularly important for the Phila project sessions, which stress teamwork, role-play activities, and open discussions.

We feel our initial goal of providing these young women with knowledge and tools was achieved, and we hope they will be able to use it to make wiser and healthier life choices as they enter the adult world. Adolescents are the future generation, which makes them one of the best audiences for health promotion. As healthcare professionals, the Phila project is a wonderful example for all of us, displaying how a healthcare professional’s involvement can have positive impact beyond hospital care. If you have any questions about the Phila project, or would like to learn more please email me at g.bouchardfortier@gmail.com.

PHOTO CONTEST: Life may be a miracle but sometimes birth needs a helping hand

International Women’s Health Symposium, June 2008

Once again this year, the SOGC will be having a photo contest as part of its international women’s health symposium. All SOGC members are invited to submit photos that reflect the theme Life may be a miracle, but sometimes birth needs a helping hand. The entry deadline is May 1st, 2008 and winning entries will be displayed at the International Women’s Health Symposium. Please read the contest rules carefully before making your submission. Complete rules and details are available on the SOGC website, www.sogc.org, within the International Women’s Health Program section. We look forward to receiving your submissions!

NEW MEMBERS

Welcome New Members

The SOGC would like to welcome some of our newest members to the society:

Member Ob/Gyn: Dr. Olalekan Mutiu Akintola; Dr. Charbel Salame; Dr. Faiza Zubair;

Junior Member: Dr. Graeme Brassard; Dr. Sheila Caddy; Dr. Carmen Nicoleta Mircea; Dr. Ally Murji;

Junior Member – Family Practice: Dr. Shamidah Noorani; Dr. Amitkumar Upadhyay;

Associate Member – MD: Dr. John M. Fotheringham; Dr. Sonia Fryer; Dr. Fabienne Grou; Dr. Katrina Sawatsky; Dr. Genevieve Tremblay; Dr. Andrea Barbara Wong;

Associate Member – Midwife: Ms. Heather Munro;

Associate Member – RN: Mrs. Diane I.M. Donaldson, RN; Miss Krisztina Eder, RN; Mrs. Lynne L. Laflamme; Ms. Wendy May Rhymer, RN; Miss Soraya M. Visram, RN;

Associate Member – Students in Healthcare Training: Ms. Magdalene Chan; Ms. Sylvie Galindo; Miss Marlies Martje Houwing; Ms. Nasserin Hussein; Ms. Sarah Khan; Miss Sarah Leavy; Ms. Sarah Lucas; Ms. Jody Medernach; Ms. Tesha Olsen; Ms. Jillian Salvador; Mr. Jason Christopher Weatherald; Mr. Douglas Michael Woudstra.

Winning entries from last year’s international women’s health photo contest. Photos 1 & 2 by Dr. François Couturier, 3 by Dr. Paul Thistle.
UNIVERSITY UPDATE: News from University of Calgary

By Dr. Nicholas Half

Greetings from Cowtown and the oil fields. So far 2007-08 has proven to be another busy year for our thriving Obstetrics and Gynaecology department at the University of Calgary.

First and foremost, congratulations to our three PGY-5s that graduated last June. It was our last three-resident year with the remaining years to have five or more. We welcomed five new PGY-1s in July and we also welcomed a family physician into our second year in January.

Our current fifth-year residents are now in full study mode for their upcoming “quiz”. The staff is graciously preparing them with sessions and practice OSCEs. Good luck Sheryl, Shannon, Jennifer, Kendra, and Gregg and congratulations to Shannon and Gregg on their successful fellowship applications.

There has been quite a baby boom in Calgary to parallel its continuing population explosion. In 2007 we had over 16,000 deliveries, breaking a 20-year record. We also have three residents who have had, or are about to have, their own baby – one they can actually take home (two baby girls thus far. It’s never too soon to become a budding gynaecologist).

RESIDENT LIFE: Mentorships

By Emile Albert, Laval University

Medical studies are long and laborious. Amid the calls, exams and rounds it is difficult to reunite professional responsibilities, continual learning and interpersonal skills in carrying out duties. Residency is a time to learn how to interact with patients. We learn by observing our professors and staff. What is the difference between an excellent mentor and a good staff? This question has no straight answer.

It requires much skill to properly explain surgical procedures or tell a couple of the in utero foetal death of their child. Indeed, mentorship qualities include leadership capability, collaboration with peers, clinical knowledge and teaching capacities. Advisors encourage residents to read more, take initiative, believe in themselves and appreciate their role in patients’ lives. Aside from “in hospital” roles, mentors often show abilities to conciliate family obligations and hobbies with their personal interests. This balance proves it’s possible to attain quality of life in obstetrics and gynaecology, despite long working hours.

To promote mentorship, awards and prizes are presented to physicians who have distinguished themselves as true advisors. Most programs do so annually by selecting one staff member who proved to be a positive model. Societies also identify obstetricians and gynaecologists that advocate women’s health. For example, last fall Dr. Michel Roy was honoured with a mentorship certificate issued by the Royal College. He gave us a little speech about his own mentor experience with Dr. Robert Kinch, who once told him, “You can have tons of experience, be the brightest clinician or researcher, but in order to have an impact on your profession and on the residents themselves you have to be there, just there…”. By that he probably meant to be yourself, show interest and passion and the rest will follow.

There can be personality conflicts. A good mentor for one may be ill-suited for another. Nonetheless, you never know when an intervention towards a resident or medical student will impact the course of his or her professional life. Remember: “be there, just there…”

Academic Half-Day: Who knew that coffee, pastry, and respiratory disease in pregnancy could make us this happy?
UNIVERSITY UPDATE: Montreal
By Béatrice Cormier

It’s been quite a year at Université de Montréal. We started off with a bang, welcoming eight new PGY-1s. We have many new fellowships this year, and Carole Bosse-Williams, one of last year’s graduates, is pursuing a gynec-onc fellowship before returning to New Brunswick.

At the end of last year we learned that Dr Marie-Josée Dupuis, our dear program director, received a prestigious promotion to teaching director for all of “Centre Hospitalier de l’Université de Montréal.” With her newfound responsibilities she had to step down from her position as program director. We congratulate her and wish her luck in this new adventure.

We have a new director, Dr. Stéphane Ouellet, who is full of ideas for the program. Among other projects, he is working on a new web page for next year. Two new centers, Trois-Rivières and Joliette, have been added to the R3 curriculum. Here, residents benefit from excellent OR exposure.

A new position of assistant program director is being created for Dr. Andrée Sansregret, one of our staff members from Hôpital Ste-Justine. These two young, dynamic doctors make a great team and have a contagious enthusiasm that is sure to bring many improvements to our program.

They have been working hard and are preparing for the Royal College visit this spring.

The second annual Symposium de Formation Générale was held in January. This event has become our most popular dedicated teaching day. Senior residents from other programs were invited to present on topics in their fields which have an impact on our patient population. We also had a special guest from Quebec Child Protective Services.

And the year is not over yet. We are awaiting Annual Department Day held in Tremblant and Annual Research Day where many of our residents are presenting. The Case Reports Evening will be held in June, one week before we have our Farewell Dinner Party for our graduating R5s.

Application dates for Junior Member Grants

The SOGC assists its members with their continuing education by providing financial support for a variety of scientific and educational programs. The application deadline dates for Junior Member Grants are:

May 15, 2008: For electives taking place between July 1st and December 31st, 2008

November 15, 2008: For electives taking place between January 1st and June 30th, 2009

For more information, please visit the Junior Member section of the SOGC website.

Menopauseandu.ca: Healthy living through menopause

The SOGC is proud to introduce menopauseandu.ca, the latest addition to SOGC’s public education and awareness online resources.

menopauseandu.ca is a comprehensive web site based on SOGC’s 2006 Consensus Report on Menopause and contains science-based information written for both the general public as well as health care professionals. Easy-to-read information about menopause that Canadians can trust, written in accessible language, with patient downloads for clinical use. menopauseandu.ca covers all aspects of the diagnosis and treatment of menopause and will provide you with an excellent resource for you and your patients.

Visit www.menopauseandu.ca today!
ACCESS TO HEALTH CARE: Survey finds Canada is not a level playing field

National Physician Survey Release
A national survey of physicians reveals doctors across Canada are concerned about inadequate access to health care services for their patients, and the situation in some provinces and territories is worse than in others.

The National Physician Survey (NPS) is Canada’s largest census survey of physicians and physicians in-training. The survey is conducted jointly by the Canadian Medical Association, The College of Family Physicians of Canada, and The Royal College of Physicians and Surgeons of Canada. This release provides the regional detail from the original release of national results in January. It updates the results found in the 2004 survey with an in-depth look at how and where physicians in each province and territory work, and the issues they face in providing care to their patients.

“The 2007 NPS confirms that the dire shortage of family physicians and certain other specialists is a significant and ongoing issue for patients in all provinces and territories,” states CMA President, Dr. Brian Day. “Some areas are worse off than others. Health workforce planning must be addressed to improve access to health care for patients no matter where they live.”

Looking for a family physician? Saskatchewan ranked the highest for the percentage of family physicians accepting new patients (45%). PEI ranked the lowest, with 2% of family physicians accepting new patients.

“Federal funding and a commitment to reducing wait times has helped improve access to care in specified areas, but the regional NPS outcomes reflect significant variations in access to specialty care,” says Dr. Louise Samson, President, The Royal College of Physicians and Surgeons of Canada. “The NPS results confirm that patients’ access to psychiatrists, orthopedic surgeons, ophthalmologists and advanced diagnostic services remain a challenge in most provinces and territories. In fact, ratings for access to orthopedic surgeons deteriorated in eight provinces since 2004. We must commit the additional resources needed to further improve access to these and other important services.”

The percentage of physicians ranking access as fair to poor differs among the provinces and territories:

- 71% of family physicians ranked access to psychiatrists in Ontario fair to poor compared to 45% of family physicians in Saskatchewan.
- 61% of family physicians in Quebec ranked access to orthopedic surgeons fair to poor compared to 26% in Prince Edward Island.
- 72% of family physicians in Prince Edward Island ranked access to ophthalmologists fair to poor compared to 25% in Saskatchewan.
- 57% of physicians in British Columbia and Saskatchewan ranked access to diagnostic services (e.g. CTs and MRIs) fair to poor compared to 34% in New Brunswick.

Several significant trends in physician practice patterns are highlighted in the NPS results:

- Gaps are being increasingly filled by a female physician cohort. Studies have shown this to have positive impacts on doctor-patient relationships, service organization, and access to services, while having significant implications for future resource planning. Currently, 33% of all family physicians under the age of 35 are women in Prince Edward Island, and this percentage rises to 72% in Quebec.
- In 2004, 26% of physicians planned to reduce their hours. The 2007 NPS confirmed that in fact 27% of physicians had reduced their hours over the last two years. Now, 35% of physicians plan to reduce their weekly work hours over the next two years – from 28% of family physicians in Manitoba to 37% of family physicians in Quebec and the Territories; and from 30% of other specialists in Prince Edward Island and Nova Scotia to 40% in Quebec.

“The NPS partner organizations challenge all levels of government and health authorities across the country to develop a pan-Canadian strategy that will effectively address the urgent issues identified in the NPS results that further threaten Canada's health system,” says Dr. Ruth Wilson, President, The College of Family Physicians of Canada. “We need to work together to enhance the education, training, recruitment and retention of physicians to ensure a sustainable workforce that can meet the health care needs of Canadians in all provinces and territories.”

For a more detailed summary highlighting the 2007 provincial/territorial results, see backgrounder and tabular results for all survey questions, at www.nationalphysiciansurvey.ca. More NPS research will be released in April 2008 to share a specialist physician analysis as well as medical student and resident results.

The NPS is funded through contributions from the Canadian Medical Association, The College of Family Physicians of Canada, The Royal College of Physicians and Surgeons of Canada, the Canadian Institute for Health Information, and Health Canada.
Does your image reflect your expertise? Do you wear your scrubs to the boardroom? Perhaps your favourite t-shirt and jeans are getting too much wear?

This event promises to be more exciting than passing your Royal College Exams! Learn the latest research on how to look great and dress for success. Fashionable scrubs, spiffy clinic wear, black tie, and travel wardrobes – understand it all at this evening of “what to wear” for both men and women.

Martinis, food stations, auctions, and models on the catwalk: A must for the health care professional!

Join us for what promises to be a memorable night.

Basics: Saturday, June 28, 2008
Telus Conference Centre, Calgary (site of SOGC ACM)
4:30 PM to 7:30 PM – Look Good Feel Better® Pre-Event Make-up and Hair Station Fundraiser, sign up at ACM (Price not included in Makeover Medicine Ticket)
7:30 PM to 10:30 PM – main event

Tickets: $125.00 (with a charitable tax receipt for $75.00)
Remember to purchase tickets when registering for the ACM!
Critical Context
Understanding Women’s Sexual and Reproductive Health and Rights Internationally

Marking Ten Years of the SOGC’s International Women’s Health Program

This year marks the 10th Anniversary of the SOGC’s commitment to improve the sexual and reproductive health of women around the world through its International Women’s Health Program. To celebrate this milestone, the SOGC News is proud to introduce this installment of a regular series of feature articles focusing on women’s health around the world. The new series, titled Critical Context: Understanding Women’s Sexual and Reproductive Health and Rights Internationally, will shed some light on the context and complexity of women’s sexual and reproductive health and rights around the world.

FEMALE GENITAL CUTTING: Examining a Harmful Traditional Practice
By Heather McMullen, International Women’s Health Program

Female genital cutting (FGC) is defined as the ‘removal of any part or the whole of the external female genitalia, or any injury to the female genital organs for traditional, cultural, religious or other non therapeutic reasons’. Between 100 million and 140 million girls and women are estimated to have undergone some form of the practice, with approximately 3 million girls being subjected each year. FGC is most common in Sub-Saharan Africa, Egypt and Sudan.

Types of FGC
What is often called circumcision or a Sunna (Type I) cutting refers to the excision of the prepuce of the clitoris. A clitoridectomy (Type II) refers to a more extensive procedure where the clitoris and the labia minora are removed. The most extensive procedure, called excision or infibulation (Type III) refers to the total removal of the clitoris, labia minora and parts of the labia majora as well as the suturing together of the remaining labia leaving a small opening for menstruation and urination. Other forms of FGC (Type IV) can include pricking, burning, scarring, stretching and other forms of excision of the external female genitalia.

FGC is most commonly performed by a senior female member of the community, often a midwife or respected tribal or religious elder. Practitioners are regularly revered for their role and earn a significant living this way. The procedure usually takes place during a girl’s childhood, in some cases during infancy or puberty and in more rare cases, at the time of marriage. The average ages are between 4-10 years old. The girl is usually unaware of what will take place but is made to feel that something special and exciting will happen to her.

What’s In a Name?
FGC is also referred to as female genital mutilation (FGM) and female circumcision. What to call the practice has been contentious, as has the issue. While supporters tend to use the term female circumcision, drawing parallels to that of male circumcision, opponents deem that term biologically incorrect and euphemistic, favouring the term female genital mutilation as they see this to be what is taking place. Some have taken issue with the word mutilation seeing this as a normative naming of a procedure that over 130 million have undergone, what is mutilation to one, is the norm for another. As a result of this the term ‘cutting’ became more commonly used. FGC is seen as the most objective description of what in fact takes place during the procedure. Many organizations, understanding the alienating capabilities of the term ‘mutilation’, continue to use it claiming it is the best way to garner opposition to the practice they believe to be wrong.

Why?
Learning about FGC often inspires an overwhelming ‘why’ in those unfamiliar with the practice. While it is commonly believed that the traditional practice is indicated in religious Islamic scriptures there is in fact no integral relationship with the practice and the tenets of Islam. The cited reasons for the continuation of the harmful practice are numerous. Many are related to history and tradition, communities claim that this is the way it has always been and if families stop cutting their daughters a number of harmful consequences will befall them. (The first known case of FGC was observed on an Egyptian mummy dating back to 200 BC).

So what is the reasoning for this practice? Firstly, FGC declares to preserve the chastity of the woman, quelling nymphomania and reducing her sexual desire, therefore ensuring her virginity at marriage and her faithfulness and submission to her husband thereafter. Many claim the practice enhances the male sexual experience and the aesthetic appearance of the vulva. Some believe the parts of genitalia that are removed in the procedure are ‘male’ aspects of anatomy and their removal ensures the girls femininity and marks her passage into womanhood. Other notions such as that the removal of the clitoris will prevent homosexuality and improve fertility and hygiene are prevalent. Mythology is also present. Another cited benefit of the practice is the ‘balancing of her psychology’.

What are the effects of FGC?
The negative effects of FGC are multiple. Short-term and long-term medical complications are common, as are psychological effects. The immediate effects may be: extreme pain, shock, infection, tetanus, blood poisoning, hemorrhage, blood loss, urine retention, damage to adjoining organs and sometimes death. Long term effects may include: cysts at the site of infibulations,

(Continued on page 12)
Chronic pain and infection, pelvic inflammatory disease, abscesses in the vulva, infertility due to scarring and infection, increased likelihood of prolonged labor and sexual dysfunction. Women have reported such psychological effects as nightmares and anxiety, depression, fear of sex, fear of childbirth, anger, loss of trust and resentment. Women also report feelings of pride, inclusion and beauty.

International Opposition

The International Federation of Obstetrics and Gynaecology (FIGO) released a resolution on the practice in 1994 stating that FGC is unethical and violates human rights principles. Other important international bodies also oppose the practice, including the WHO, UNICEF, UNFPA and the International Confederation of Midwives. International protocols, statements and agreements also denounce the practice. Common strategies to reduce the practice have included criminalization, public education campaigns, liaising with community leaders, religious, political and cultural in opposition to the practice.

Not Medically Indicated – The Risks of Medicalization

There are no medical benefits to FGC. In fact, the practice violates the human right to the highest attainable standard of health and to bodily integrity in the absence of any medical benefit. It is discrimination based on gender and a violation of the rights of the child. Recent attempts to medicalize the practice by having doctors perform FGC with the use of anesthetics and sterile equipment are considered stealth attempts to legitimize the practice and quell opposition.

What is being done?

In an attempt to keep with tradition alternative rites of passage have been developed to replace FGC. Retreats for girls entering puberty where the importance of personal hygiene and their role as women are discussed and celebrated with song and dance are being promoted as alternatives for families who wish to honour their cultural traditions. In some communities safe houses for girls have been established. Having political and religious leaders speak out against the practice has also been seen to be an important tool to encourage an end to the practice. Public education surrounding myths regarding FGC are another strategy.

Additionally, many countries have banned the practice, making it illegal and occasionally charging practitioners with criminal activity.

Criminalization has not inspired a significant reduction in FGC. While it is seen as positive to criminalize the practice, there have been legitimate concerns that this is pushing the practice more underground, making the circumstances under which the girls receive the procedure all the more dangerous. For sustainable prevention there has been a push to train practitioners in other lucrative skills so that they do not continue to rely on their incomes as FGC providers.

Men need to be onboard to stop the practice. Many women fear their daughters won’t be able to marry without FGC. Organizations have been actively engaging men in dialogues about the harmful effects of FGC in an attempt to stop the practice from continuing.

FGC is present in Canada.

Canadian health care practitioners need to be aware of the practice. Women with FGC have reported negative experiences at the hands of Canadian health care providers, others have been pleased with the sensitivity and support doctors and midwives have provided.

Caring for all people with sensitivity and respect is important and all deserve to have their sexual and reproductive rights protected. Health care practitioners may feel discomfort when caring for women with FGC, particularly if there are requests for re-infibulation. The FIGO guidelines and WHO publications on FGC and texts such as “Female Genital Mutilation and Obstetric Care” by Beverley Chalmers and Kowser Omer-Hashi can help health care practitioners learn best practices when caring for these women.

Suggested Resources:

Book: “Female Genital Mutilation and Obstetric Care” by Beverley Chalmers and Kowser Omer-Hashi

Film: ‘Mooladé’ by Ousmane Sembene

Web: Female Genital Mutilation Education and Networking Project www.fgmnetwork.org

Resolution: FIGO Resolution of Female Genital Mutilation, available at www.figo.org
Vagifem® was demonstrated not to raise plasma estrogen levels outside the range seen in post-menopausal women (clinical significance of this finding was not established). In atrophic vaginitis, this locally applied treatment eases vaginal dryness, soreness and irritation, and has been shown to improve painful intercourse with virtually no systemic absorption. And because Vagifem® is a vaginal tablet, patients preferred its comfort (~92% vs. ~50%), ease of use (~93% vs. ~66%) and overall acceptability (~77% vs. ~25%), p ≤ 0.001, vs. conjugated estrogen vaginal cream. Prescribe Vagifem®. Because symptoms of atrophic vaginitis don’t have to compromise intimacy.
Stress Urinary Incontinence (SUI) is bladder leakage resulting from physical activity such as laughing, running, sneezing or picking up a child. It affects 30% of women worldwide.

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A project has been in gestation this past year at the International Women’s Health Program (IWHP) of the SOGC and the team is pleased to announce the much anticipated birth of a new 26 month ALARM International Program (AIP) in Guyana, South America.

A surprising number of SOGC members volunteer in Guyana where they have persistently encouraged us to bring the AIP. Though maternal mortality rates in Guyana are on the decline (MMR of 140.1/100,000 in 1991 down to 113 in 2006), they remain high when compared to other Caribbean nations, prompting the authorities of the Georgetown Public Hospital to contact us in 2007 with a proposal to provide AIP training for staff. Encouraged by this enthusiasm, the SOGC chose to partner with PAHO (The Pan American Health Organization) in an attempt to cover as many, if not all, the obstetrics health staff in the country.

PAHO’s interest in funding our initiative was clear and the need for ongoing training already well documented in a situation analysis conducted in June 2005. “The opportunity for professional and career development is a key factor in retaining skilled health professionals in the public sector. Providing better women’s health care will also improve the capacity for all women working in the public and private sectors in the country. This will decrease sick leave time, decrease the need for women to leave the country for health reasons, and improve morale in the public service.”

The final agreement was signed in December 2007 and involves delivering 10 AIP courses in Guyana over two years, reaching approximately 400 health professionals. We firmly believe however that training alone will not bring down maternal mortality and morbidity unless care is taken to verify and support the change in practice.

To ensure the adoption of the life-saving practices that the AIP promotes will require support and supervision by agents of change. We would love to believe the Active Management of the Third Stage of Labor (AMSTL) is practiced by all who have participated in the AIP. Or that all delivering women in the given country will have a person of their choosing support them through their labour (i.e., a doula, husband or family member). But how can we ensure our impact? These are questions that we have been focusing on here at the IWHP. One important prerequisite is that the AIP should be taught within a framework of other activities all aiming at the reduction of maternal mortality. Program countries must enter into an ongoing partnership with the SOGC which will strive to support them in instituting regular maternal death audits. We aim to continue gathering baseline data to guide our programs. Our driving force is those 500,000 plus women who are dying in childbirth every year. Filtering our programs through a “do no harm” perspective is also an essential component in the type of development work that we do. What practices should we be exporting to a mid-level developing country like Guyana? What kinds of technology or medication should we be promoting? If we were working in a developing country and had $10,000 to spend, would we buy an electric fetal monitoring system or a regular supply of oxytocin? We recently asked ourselves questions like these on a pre-course seminar held in Guyana’s capital, Georgetown. There, two of our SOGC experts, Eileen Hutton and Eric Stearns, joined me in meetings with the incredible team of Guyanese maternal health stakeholders who form the National Committee for the ALARM International Program in Guyana (NCAIG). They were given the AIP manual to read prior to our arrival on Feb 4.

Over an interesting, and at times revealing, two day period, we engaged with NCAIG members in discussions regarding their standard obstetrical practice, their challenges and in particular what the AIP promotes. They described the circumstances under which they care for the women of Guyana. We learned that up to 75 per cent of Guyana’s population lives along the coast and the rest are scattered throughout the remainder of the country, some in geographical isolation. Over 90 per cent of births occur in the two main hospitals (the Georgetown and New Amsterdam Public Hospitals) where all women are encouraged to deliver.

One of their most pressing concerns is the constant erosion of health care workers to other Caribbean nations for better pay and work conditions. This preliminary mission to Guyana was an exciting learning experience. Throughout 2008-2009 the IWHP looks forward to collaborating with the professional team of individuals we met in Guyana as well as the dedicated volunteers of the SOGC who make these activities possible.

Our first course begins April 18, 2008.
21st INTERNATIONAL CME
La Antigua, Guatemala

From March 10th to 14th, the SOGC travelled to beautiful Antigua, Guatemala for our 21st Annual International Continuing Medical Education program. The event was an outstanding success with over 140 delegates attending from Canada and Guatemala. Special thanks to everyone who participated, our fascinating speakers, our sponsors, and the staff and volunteers whose hard work made the event one to remember. We’re looking forward to seeing you all again next year’s event in Cancun, February 28th to March 7th, 2009. For more information on the International CME, and all of SOGC’s CME events, visit www.sogc.org.