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Transcervical sterilization: Population sterilization rates overestimated

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Conflict of interest

None.

Authors' contributions

I conceived and wrote the entire piece.

Authors' information

Dr Kieran Walsh is clinical director of BMJ Learning and Quality.

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Reference

- [1] Scheele F, Novak Z, Vetter K, Caccia N, Goverde A. Obstetrics and gynaecology training in Europe needs a next step. *Eur J Obstet Gynecol Reprod Biol* 2014 (May) pii: S0301-2115(14)00223-1.

Reforms needed to the system of obstetrics and gynaecology training in Europe



Dear Editor,

Scheele et al. have offered an interesting overview of the reforms needed to the system of obstetrics and gynaecology training in Europe [1].

Their suggestions are likely to be what is required – however it is sobering to review the number of reforms suggested. The suggestions include e-learning programmes, simulation, team training, professionalism development, reflective practice, continuous formative assessment and feedback, summative assessment for independent practice, faculty development, patient feedback, assessing quality of care, and assessing the quality of training. How will the average department of postgraduate training in obstetrics and gynaecology deliver all these reforms (eleven in total) and at the same time continue to provide clinical care and conduct research?

The answer might lie in packaging a number of these reforms together and seeking efficiencies as a result. There are a number of examples that come to mind almost immediately. Firstly simulation and team training need not be twin track ideas – they can be integrated. Simulation works best when it is a team based learning activity and as a corollary team learning works best when teams role play how they would perform in realistic situations. Secondly there is considerable overlap between the ideas of

e-learning programmes and simulation. With modern technology e-learning programmes can be interactive and multimedia and can simulate the real world with a virtual one. Equally simulation scenarios can be filmed and resultant media put online. Thirdly the paper mentions formative assessment and summative assessment – however there is similarly potential for integration here. The concept of progress testing allows the assessor to take the best of formative and summative assessment and develop a solution that works well for the examiners and examinees. Lastly and perhaps most importantly there should not be an artificial divide between assessing quality of care and assessing the quality of training. Training should only happen in a high quality care environment – in this circumstance the trainees will learn from experience and from their senior role models.

Scheele et al. have rightly presented the challenges that modern curriculum designers face – the next step will be strategic implementation. Resources might be limited and so we will have to think how to design curricula that are both effective and efficient.

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Transcervical sterilization: Population sterilization rates overestimated



Dear Editor,

I read with interest the study by Fernandez et al. [1] reporting the pregnancy rates in France between women who had sterilization by laparoscopic or hysteroscopic methods. Unfortunately, the authors fail to recognize a significant limitation of the dataset and the results, accordingly, are misleading to both patients and providers. Fernandez et al. [1] provide pregnancy rates from a national database in women who successfully had each procedure. For the patient, she enters a procedure or operating room to have a sterilization procedure performed and, with transcervical sterilization, she is significantly more likely to not have that procedure completed. In fact, the likelihood that a woman will be successfully sterilized within one year of the initial procedure is significantly lower with transcervical than laparoscopic sterilization [2]. All women attempting sterilization, not just those who successfully have the procedure, need to be considered when evaluating the public health benefits of a procedure. Because women who desire transcervical sterilization are significantly less likely to achieve sterilization, the pregnancy rate in the total population (not just those that successfully have the procedure) is significantly greater over 10 years in women desiring transcervical sterilization as compared to laparoscopic sterilization [3]. The conclusion of

Fernandez et al. [1] that the “lower pregnancy rate for sterilization by tubal microinserts justifies the development of this technique and its preference by the health authorities” is not supported by the totality of the available information in the literature.

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