The new normal

Deputy Editor-in-Chief, Prof Aris T Papageorghiou, discusses the latest thinking in women’s health and highlights articles from this issue in an audio podcast available at: https://soundcloud.com/bjog/june-editorial-2020

This morning the spring flowers were in full bloom, as if nothing had changed. It struck me how the ‘new normal’ takes hold so very quickly. COVID-19 has affected our ‘normal’ beyond recognition. It has already changed our individual relationships with our families, our patients, our colleagues, the outside world and the government. The impact on health continues to grow and the virus has claimed tens of thousands of lives. At population level, whole regions and countries are in lockdowns, and this has led to a severe slowdown in global economic activity. This ‘new normal’ could not have been imagined just a few weeks ago.

The effects of the virus on healthcare staff have been particularly severe, exemplified by the sad death of Dr Li Wenliang, the Wuhan ophthalmologist who warned about a possible outbreak of an illness that resembled severe acute respiratory syndrome (SARS; Green Lancet 2020;395:682). He is one of hundreds of healthcare workers who have died of COVID-19, movingly listed on the online In Memoriam webpage (https://www.medscape.com/viewarticle/927976).

As medical journal editors, we have been trying to contribute to the dissemination of information. As part of this, we have recently launched the BJOG COVID-19 Resource Centre (https://obgyn.onlinelibrary.wiley.com/hub/journal/14710528/covid-19_resource_centre), which is a collection of useful and credible links to guidelines, registries, systematic reviews, websites and primary articles. This includes experience on the ground: in a fast-tracked paper on pages 786–88 of this issue of BJOG, Chua and colleagues comment on our preparedness for the pandemic. The paper makes practical recommendations on how to assess and screen, describes the impact of pneumonia, and makes suggestions for care during labour and delivery as well as the postpartum period.

During the pandemic, we must also remember that healthcare needs unrelated to COVID-19 continue: babies are still being born, medical emergencies still happen and individuals with unrelated life-threatening conditions are still in need of treatment. In fact, there is evidence that such care is negatively impacted; despite our assurances, people may choose to avoid hospital visits out of fear of contracting the virus, or may be unable to access stretched hospital transport or simply want to avoid ‘clogging’ the medical system. As an example, Tam and colleagues (Circ Cardiovasc Qual Outcomes 2020;13:e006631) used data from Hong Kong to show that patients experiencing symptoms of a heart attack delayed seeking care during the outbreak.

Contained in the June issue of BJOG are papers that deal with a variety of issues we face in our daily practice. On pages 829–37, in a cluster-randomised controlled trial of almost 40 000 women in 67 maternity clinics in Sweden, Akselsson and colleagues report on mothers who underwent a programme to improve awareness of fetal activity compared with normal care. However, the conundrum is that most previous intervention trials following a reported reduction in movements increase the proportion of women attending hospital and receiving interventions, but without a reduction in stillbirths. It should also be said that trials have mostly been underpowered to demonstrate such a reduction. Read the study by Akselsson and the accompanying commentary by Heazell on page 838, and see whether you agree that such focussed awareness of fetal activity is a reasonable approach to evaluating fetal wellbeing.

How fetal growth and the fetoplacental circulation are affected in women who become pregnant after bariatric surgery is reported in a prospective study by Maric and colleagues on pages 839–46. Birthweight in infants from women with bariatric surgery was lower – by an average of 200 g – compared with infants from mothers without such surgery. This was also reflected in ultrasound fetal growth parameters, but there were no large differences in fetoplacental Doppler indices, suggesting that altered maternal nutritional and metabolic/ carbohydrate milieu is responsible for this difference.

Other important questions about the care we provide every day remain despite the COVID-19 crisis. How can we reduce urinary complications after radical hysterectomy (pages 859–65)? What pregnancy outcomes should we expect *BJOG papers are published online long before issues appear, and we will continue to fast track relevant articles on the subject, so check in regularly on our website and social media channels. At the same time, we have rejected a number of articles – rejecting papers on COVID-19 in pregnancy may seem odd at a time like this, but we defend such decisions, as individual case reports, small series or opinions may have little to offer our clinical readers. We are particularly interested in studies that demonstrate important principles with wide applicability, prospective cohorts or case series, and studies of diagnostic methods and of treatments, and these will be assessed rapidly and thoroughly.© 2020 Royal College of Obstetricians and Gynaecologists
in women with primary biliary cholangitis and primary sclerosing cholangitis (pages 876–84)? What is the role of point-of-care coagulation testing in obstetrics (pages 820–27)? Finally, how can practitioners in low-resource settings deal with limited imaging and lab testing before fistula repair (pages 897–904)?

Of course, the pandemic will pass. Our questions around how we can improve women’s health will continue, but we should also think about how life may be different after this crisis and how we can influence this. Will we just return to our previous day-to-day? Will the immense sense of gratitude, expressed the world over towards all those putting their own health (and lives) at risk to support healthcare remain, or be quickly forgotten? Will the new-found faith in serious experts dissipate, as it has done before? Will we concentrate efforts on solving other global issues such as the climate emergency? Much has been written and only time will tell, but we should all be prepared to contribute and prepare for what will be the new normal after the pandemic. As obstetricians and gynaecologists with a global view, we should be particularly aware of the possible consequences for women’s health, particularly in underserved regions. This was highlighted in a recent statement by Executive Director of the United Nations (UN) sexual and reproductive health agency, Natalia Kanem at the UN Population Fund (UNFPA; www.unfpa.org/press/women-girls-health-workers-must-not-be-overlooked-global-covid-19-response). It discussed the risks of disruption in access to care at a time when it is needed most owing to resources being funnelled away from sexual and reproductive health services towards targets perceived to be more pressing. The UNFPA has vowed to fight this tendency stating, ‘Safe pregnancies and childbirth depend on functioning and accessible health systems’. The report draws on lessons from the 2014–16 Ebola epidemic in Liberia, Guinea and Sierra Leone; a huge surge in maternal mortality was recorded not just during but also after the outbreak, as women stayed away from medical facilities. The UNFPA is pressing for the full maintenance of sexual and reproductive health services during the COVID-19 outbreak, which should include antenatal and postnatal care, access to modern contraception and emergency contraception, and safe abortion and post-abortion care ‘to the full extent of the law’. The UNFPA is also calling for priority testing of pregnant women with COVID-19 symptoms, isolation of pregnancy wards from confirmed cases, an elevation of care for any pregnant women with respiratory illnesses and extra care for all women in delivery, in case breathing complications should arise. Importantly, the UNFPA also warns of the potential exacerbation of existing financial inequality between men and women, and the longer-term impact this may have: globally, women are more likely to hold precarious or vulnerable jobs, which are often the first to be lost during financial shocks. Women are also more likely to shoulder higher proportions of the domestic burden during lockdown; all of this may have contributed to the spike in gender-based violence seen amid the pandemic.

Yuval Noah Harari, author of Sapiens, Homo Deus and 21 Lessons for the 21st Century, recently wrote a thought-provoking article in The Financial Times (www.ft.com/content/19d90308-6858-11ea-a3c9-1fe6fedca75). He wrote: ‘The decisions people and governments take in the next few weeks will probably shape the world for years to come. They will shape not just our healthcare systems but also our economy, politics and culture. We must act quickly and decisively. We should also take into account the long-term consequences of our actions. When choosing between alternatives, we should ask ourselves not only how to overcome the immediate threat, but also what kind of world we will inhabit once the storm passes’. He presents stark choices, between totalitarian surveillance and citizen empowerment, and between nationalist isolation and global solidarity. We should all contribute towards shaping the new ‘new normal’, coming our way.

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Please visit the BJOG COVID-19 Resource Centre
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