

Movin' On

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Editor-in-Chief

Fresh from our experience with a break-in at the Journal's editorial office, we have now had another challenge: moving the office from a tertiary care general hospital to a tertiary care women's hospital. This has involved not just a change in location, but also a change in working environment.

Although we had a year in which to plan this move, inevitably we were blind-sided by complications that we did not foresee. The fact that you have received this issue of the Journal is in itself a minor miracle; but now we have no more excuses for being unavailable or slow in responding. Alert readers will note the changes in the Journal's masthead and especially our contact numbers. We would have been delighted if we had been assigned 1-800-NEW-JOGC or similar, but sadly it was not so. Memorable telephone numbers are the new precious jewels, to be coveted and bartered for, and although we are coveters we are not barterers. So we have numbers that I must keep looking up; but our email contacts remain intact, and we welcome electronic communications more than ever. In fact, the workings of the Journal are enhanced, we hope, because our offices are more functional.

Time will tell if this physical relocation is an overall success. So far, the differences between being located in a women's hospital and in a general hospital are limited to a few observations:

1. The hospital corridors are much more crowded, and I have the impression that some meetings are actually held in corridors rather than meeting rooms. I have spent a lot of time dodging groups of staff wearing name-tags and conducting heated discussions, whereas in our previous location the corridors were always empty.

2. Although the new hospital is smaller, I have seen at least four coffee outlets (for three national brands); the enormous general hospital had two. To paraphrase Bette Midler, there seems to be coffee everywhere, but nothing gets done any faster.

3. The IT services at the general hospital appeared to have been outsourced, such was the anonymity of any help we ever received. At our new location, the IT services appear to consist of three men (one, or perhaps all, named Jeff) who promise to do things and, surprisingly, almost always do.

4. Directions at the women's hospital have a democratic flair, in that there is a multitude of hand-drawn and professional signs adjacent to every elevator directing visitors to a variety of clinics and units. At the general hospital, signage was austere, uniform, and (I thought) unfriendly. Of course, we don't know which of these is more effective for getting people where they need to be.

Our new environment is a visibly younger one, since we are surrounded both by women of reproductive age and children attending the children's hospital. Although the mood of the women's hospital tends to be happy, with 8000 deliveries annually, the presence of some very ill children gives poignancy to the mood of the children's hospital. The frequent clatter of a helicopter's arrival or departure also reminds us that this institution, despite having a narrower clinical focus than the general hospital, is very much a tertiary and quaternary referral centre, and that this is a big country. Providing the best possible care in Canada is heavily dependent on transport, as illustrated by the article by Louai Jony and Tom Baskett in this issue. Their review of reasons for pregnant women to require emergency air transport showed that almost two-thirds of such women faced a possible preterm delivery, and they conclude that better methods of identifying women who are genuinely at risk for preterm delivery should reduce the need for such emergency flights. This conclusion should not be taken lightly; in 1995, an emergency flight to transport a patient in labour crashed off the British Columbia coast. All on board

EDITORIAL

were killed, including a young resident in the UBC program, Jeffrey Dolph. Their deaths still resonate in the BC obstetric community.

On another topic, young women seeking termination of pregnancy were found to be less at risk of having experienced intimate partner violence than their older counterparts, according to the study reported by Dominique Bourassa and Jocelyn Bérubé. However, they found an alarmingly higher prevalence of violence in women who were seeking abortion than in women who were continuing with pregnancy. This article stresses the importance of caregivers actively seeking out those women who are either at risk of, or experiencing, intimate partner violence. A valuable resource for this is the Intimate Partner Violence Assessment Toolkit, available for downloading from the SOGC website. We must keep this subject in view.

This issue of JOGC also includes the second in the five-part series of articles by Gregory Davies and William Herbert

focusing on cardiac disease in pregnancy. The present article reviews congenital heart disease in pregnancy, which accounts for approximately three quarters of the heart disease seen in pregnancy according to Canadian estimates. Subsequent articles in this series will review acquired heart disease, coronary disease and cardiomyopathy, and prosthetic valves and arrhythmias in pregnancy; they will provide more reasons not to discard copies of the Journal, although they will be available, as always, on our website.

Now that we are settling into our new location, I must thank our contributors and correspondents for their patience and good humour during our transition. We hope that all the setbacks are now behind us and that you will receive stellar service from our office from this point on. At least we have no shortage of coffee . . .