

The background of the entire page is a close-up photograph of a nest. It contains five eggs. Two are plain, light-colored, and smooth. Three are speckled with brown and reddish-brown spots on a lighter background. They are nestled in lush green grass and small plants.

O&G

Magazine

Vol 15 No 3 Spring 2013

Nurturing the profession

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists



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Nurturing the profession

- 11 Editorial
Gillian Gibson
- 12 O and G is in our hands
Andrew Pesce
- 16 Towards 2025
Rupert Sherwood
- 23 Workforce planning in NZ
Dereck Souter
- 26 Lost, but not alone, in the labyrinth
Chris Hughes, Sarah Tout, Lyn Johnson
- 28 Safe working hours and surgical training
Michelle Harris
- 30 Everyday academia
Celia Devenish
- 34 Why be an academic?
Ian Symonds
- 36 The future of GP obstetrics: have we done enough?
Jeff Taylor
- 38 Training GP proceduralists
David Iser
- 39 Rebirth of the rural generalist
Tony Urquhart
- 40 DRANZCOG training in FNQ
Alexa Bendall
- 42 Post-DRANZCOG pathway
Louise Sterling
- 44 Motherhood and medicine
Alex Mowatt
- 46 Walking in their shoes
Anne Coffey and Brad Robinson
- 50 Women in medicine
Susan Evans
- 52 The gentle art of lobbying
David Molloy

Review

- 54 Ogilvie's syndrome
Amin Bahabri, Barton Smith, Paul McGurgan

Women's health

- 59 *Q&A*: VBAC with doula
John Svigos
- 61 Journal Club
Brett Daniels

Letters to the editor

- 62 The drunk consultant
David Blackledge
- 62 Experience-based medicine
Graeme Dennerstein

The College

- 5 From the President
Michael Permezel
- 8 From the CEO
Peter White
- 62 Notice of Deceased Fellows
- 63 Rare incubator acquired
Gráinne Murphy
- 64 RANZCOG Research Foundation
Jonathan Morris and Caroline de Costa
- 66 Capacity building and teamwork in the Pacific
Carmel Walker
- 69 Coming together to meet common goals
Alec Ekeroma
- 70 College Statements Update
Stephen Robson
- 71 Farewell to La Trobe Street
Ros Winspear and Bree Morrison
- 74 Staff news
- 74 Queen's Birthday Honours
- 76 Obituaries

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From the President



Prof Michael Permezel
President

Many Fellows will be aware by now that the College CEO, Dr Peter White, has accepted a senior position with the Australian Medical Council (AMC) and will be leaving the College at the end of September, after more than a decade of outstanding service. I am sure all Fellows will join with me in wishing Peter well in this exciting new development in his career with the AMC. The Board has set in place a process that will begin the difficult task of replacing a long-standing and effective CEO.

In July, I attended the Pacific Society for Reproductive Health (PSRH) meeting in Samoa. All those

involved with this group are to be congratulated – particularly the College staff led by Carmel Walker; the Chair of the Asia Pacific Committee, Dr Ken Clark; and the current President of PSRH, Prof Alec Ekeroma. Along with the Brian Spurrett Foundation and the College, PSRH supports both obstetricians and midwives in the

delivery of reproductive services in the Pacific island countries. There are many fine stories to tell of dedicated individuals, working in conditions of extreme resource deprivation. Countries with a few thousand births and a single specialist who is on call 24 hours a day, 365 days a year as the only health practitioner able to perform a caesarean section in the nation. The efforts of PSRH, the Brian Spurrett Foundation and the College are genuinely appreciated, but we need to look to do even more. It was particularly pleasing to see the PSRH President's Medal being awarded to Prof Glen Mola from the University of Papua New Guinea. Glen is well known to many at the College and embodies the dedication displayed by many clinicians in the Pacific countries.

A/Prof Robert (Bob) Bryce of Flinders Medical Centre received the RANZCOG President's Medal at July Council. He has a history of more than 20 years in developing the College's assessment processes. His particular expertise in standard setting placed the College well in advance of most other medical colleges and universities. This and other important contributions should have the College well placed to meet the assessment expectations of the AMC accreditation team when they visit the College next month.

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The revised College integrated training program (ITP) is absolutely central to the College vision for Trainees and our future Fellows. The quintessential feature is more formal structuring of Advanced Training (formerly Elective Training). As now, all Trainees will have to attain the core knowledge, skills and attributes that comprise a minimum of four years of Core (ITP) Training. However, in the revised training program, the last two years of training will consist of a series of selectives known as Advanced Training Modules (ATMs).

Attempts to improve Advanced Training face critically important challenges. One area of increasing training concern is the 'overseas Fellow'. Some of the best positions for advanced training are occupied by overseas Trainees. One prominent Australian teaching hospital recently had six overseas Fellows – some or all may be taking training that could be useful to local Trainees. In a few isolated cases, this is part of an exchange program in which both countries benefit. More usually, employment of an overseas Fellow is one-way and incentivised by obvious benefits to the local consultants – but of much less benefit to local Trainees who perceive a loss of advanced training opportunities. The College will have to look at possible strategies to make more of this excellent Advanced Training available to Australian and New Zealand Trainees.

Equally concerning with regard to the potential to reduce Advanced FRANZCOG Training opportunities is the ever-present trade-off between super-specialisation and generalism. Super-specialisation in the 'left fourth toe' will produce unequalled and exemplary management of that vital organ, but creates a therapeutic quandary if there are concurrent disabilities and the poor patient has to find a separate medical practitioner for each ailing digit. Generalism improves equity of access for the patient and clearly there is a need for a careful balance between generalism and specialisation. The College training program has, historically, had to balance the sometime competing objectives of depth and breadth of training. College support of the Subspecialties and the planned Advanced Training Modules in areas of special interest are testament to

recognition of the need for a subset of Trainees to be equipped with increased depth in specific areas. These initiatives occur within the College training structure, being cognisant of the need to balance training opportunities for generalists against a workforce need for a limited number of clinicians with special expertise in specific areas. As with overseas Fellows, local hospital incentives may work against training the local 'generalist'. A future 'super-specialist' Trainee on a two-year focused program will require less supervision and be more clinically productive than the alternative of, say, two 'generalist' Trainees, each on 12-month rotations. There will also be half the number of new Fellows leaving the training program with the special skill set (albeit at a higher level). These are some of the challenges facing a College that is committed to training both the generalist (with special interests) and a relatively small number of super-specialists as required by the workforce demand.

The colposcopy quality improvement program (C-QulP) has a similar dilemma, albeit at a different level. Where advanced laparoscopic surgical training must balance the competing needs of the generalist with an interest and the super-specialist, the issue for colposcopy is whether it should remain a core skill (in other words, within the capability of all Fellows) or should it become an area of special interest that is only practised by a section of the Fellowship? New recommendations for C-QulP will put participation within the capability of most Fellows. These are really important developments, not only for colposcopy but also as a benchmark for practical, effective – and achievable – continuing professional development.

The College will have its AMC accreditation visit in the first week of September. This is the first such visit in a decade. It will present some undoubted challenges, but is also an opportunity to gain constructive feedback across a range of College activities encompassed by the AMC accreditation standards. The AMC visit will be followed immediately by the College Annual Scientific Meeting in Sydney and I look forward to seeing as many of you as possible at that important event.



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From the CEO



Dr Peter White
CEO

Having taken the decision to move on from RANZCOG at the end of September, it is with a mix of emotions that I begin to write my 30th 'From the CEO' contribution to *O&G Magazine*. The column is being composed immediately following the July meetings of the College Board and Council and many of the committees who oversee the myriad functions that make up the activities of the College. A quick calculation before the July Council meeting determined that I was about to deliver my 23rd report to the College Council, having attended some 50 or so meetings of the College Board/Executive

during my tenure. I have referred recently to the somewhat cyclical nature of core College events and it will, most likely in the first instance, be a little unusual to have new cyclic rhythms governing my professional activities following September.

While it may be tempting, even natural, to look back and reflect at some length on the period spent in a position such as that which I have had the privilege to occupy for the past seven and a half years, I will not do so here, save for noting the proactive ways in which RANZCOG as an organisation has evolved to face the challenges presented by the environment in which it has operated during that time, and to note, notwithstanding the challenges still to be considered, the organisation is well placed to continue to develop in a manner that will enable it to meet the needs of its members, in a way that will also satisfy the requirements of its external stakeholders.

I have written previously of the conception of leadership expounded by Thomas Sergiovanni, a US academic who was seminal in introducing the concept of transformational leadership in the education sphere and proposed the concept of 'pedagogical leadership' in relation to school leaders. Pedagogical leadership is the stewardship of shared ideas, values and commitments that lead to better outcomes for students in schools through the development of human and academic capital. This concept has, in my view, particular value in organisations such as RANZCOG, where staff and members, particularly those in senior positions, work to develop the organisational entity and produce the best-possible organisation.

I have been privileged to work with a large number of individuals over more than a decade in my employment with RANZCOG and all involved with the organisation have my gratitude for the commitment they have made to the stewardship of the College, and for the opportunities for personal and professional growth that they have afforded me. I long ago realised that my responsibility was to work with others to steward the College through a phase of its development and I am hopeful that I have accomplished this in a positive manner that can be built on subsequently.

Since the previous issue of *O&G Magazine*, activities and arrangements associated with the reaccreditation of the College by the Australian Medical Council (AMC), on behalf of the Medical Board of Australia and in collaboration with the Medical Council of New Zealand, have continued to progress. The College's

reaccreditation submission and the supplementary submission composed in response to a request for further information relating to aspects of the original submission are available on the College website at: www.ranzcog.edu.au/the-ranzcog/ranzcog-submissions-reports/submissions.html, and I would commend both these documents to readers as a most useful source of information in relation to the College's activities.

As part of the reaccreditation process, external stakeholders have been invited to comment on the College's reaccreditation submission and surveys from the AMC have been distributed to College Trainees and Training Supervisors (including ITP Coordinators), as well as specialist international medical graduates (SIMGs) who have applied to the College for assessment of their qualifications obtained overseas. The next phase of the process involves visits by members of the accreditation team in the last week of August to a range of training hospitals and other stakeholders throughout Australia and New Zealand. The training sites selected collectively represent the full range of training experience: tertiary and secondary training centres, rural training sites, public and private hospitals, those utilised under commonwealth STP funding and subspecialty training sites.

The reaccreditation process culminates with a series of meetings of the accreditation team with members of key College bodies, to be held 2–4 September, at College House. The range of College bodies identified by the accreditation team with which they will meet reflects the nine accreditation standards against which the College is assessed and, in addition to the Board, consists of the:

- CPD Committee;
- Education and Assessment Committee;
- Education Strategy Committee;
- Indigenous Women's Health Committee;
- SIMG Assessment Committee;
- Subspecialties Committee;
- Trainees' Committee;
- Training Accreditation Committee; and
- Women's Health Committee.

The accreditation team will present a preliminary statement of findings to members of the Board on Thursday 5 September, and it is anticipated that the outcome of the process will be known by the end of the year.

An article in the previous issue (Winter 2013) of *O&G Magazine* described changes to the RANZCOG Training Program to operate for Trainees from 1 December this year. Following the adoption in March by the Board and Council of new regulations for the revised training program, revised regulations for current Trainees that will operate from 1 December 2013, as well as two other sections of reformatting and revised regulations were approved by the Board at its meeting in May. The remaining three sections of regulations – SIMG assessment, subspecialty training, and CWH/DRANZCOG/DRANZCOG Advanced training – were considered and approved by the Board at its meetings in July and will, from 1 December 2013, form part of a separate regulations document that will exist independently of the RANZCOG Training Program Handbook in which the regulations are currently contained.

Since the approval of the regulations for the revised FRANZCOG Training Program, the revised training documentation that will be introduced for all Trainees, both current and newly commencing, in relation to periods of training that commence on or after 1 December 2013 has also been approved, and correspondence sent to all Training Supervisors, ITP Coordinators and current Trainees regarding the revisions to the Training Program. This is important information for these groups that should be read and understood. As previously indicated, the College is extremely cognisant of the need for wide-ranging communication in relation to this activity and has established an email address to which any specific enquiries about the revised training program can be sent: revisedtrainingprog@ranzocg.edu.au.

I would urge all readers who have any involvement with the FRANZCOG Training Program to familiarise themselves with the detail of the introduction of the revised training program, take advantage of the available information offered through communication from the College this year (see also: www.ranzocg.edu.au/revised-training-program.html) and to assist in promulgating accurate information in relation to the revised training program as opportunities arise.

As I write, arrangements for the RANZCOG 2013 Annual Scientific Meeting (ASM) in Sydney are now approaching the final stages. The meeting has a range of speakers, an interesting and varied scientific program, built around the meeting theme 'Evidence in O&G: Food for thought or recipe for disaster?' and a social program that includes dinner on the foreshore of Sydney Harbour. As always, the success of these meetings is owing to the work of the Organising and Scientific Committees and I take this opportunity to thank members of both committees as well as Ms Kylie Grose, ASM coordinator, Ms Lee-Anne Harris, sponsorship coordinator, and Ms Val Spark, CPD senior coordinator, for their work in this regard.

As always, the meetings indicate the ability of RANZCOG members and staff to work together to deliver quality professional development activities, with programs that appeal to a range of College membership groups. The College is also continuing its promotion of the joint Royal College of Obstetricians and Gynaecologists (RCOG)/RANZCOG World Congress to be held in Brisbane, 12–15 April 2015, and delegate interest during the recent RCOG Congress in Liverpool, at which the College had a presence, augurs well for another highly successful collaborative meeting, arrangements in relation to which are well underway.

The RCOG is clearly of significance for RANZCOG, given the origins of both the Australian and New Zealand entities that amalgamated in 1998 to produce our College. Recent meetings with staff and office bearers between the two organisations have, however, reminded us that there is still much that both organisations can learn from each other and relationships between the two colleges are very strong. Increasingly, there is realisation of the value of communication and collaboration with similar international societies and I am confident that a targeted international presence for RANZCOG will be of benefit to the College in coming years.

RANZCOG can learn from international organisations and settings as well as contribute much, points that were brought home through the RCOG meeting in Liverpool, as well as the recent biennial meeting of the Pacific Society for Reproductive

Health (PSRH) in Samoa. While both meetings were successful in their own right, the PSRH meeting again served to remind those present of the difficulties faced in delivering quality women's healthcare in our regional neighbours and served as yet another reminder of the role that RANZCOG can, and does, play through its ongoing support of PSRH and related initiatives in the Pacific region, which are coordinated through the Asia Pacific Committee.

Over the past decade or so, many College Fellows and Diplomates will have worked on College activities with Ms Valerie Jenkins. Valerie has recently announced her intention to formally retire after some 13 years at the College, during which she has been instrumental in the implementation of a wide range of initiatives that have been of direct benefit for the College Fellowship, particularly Provincial Fellows, as well as College Diplomates, and advocated strongly for the provision of robust, quality, achievable CPD activities for Fellows.

Among many other achievements, Valerie was responsible for the development of the Victorian Managed Insurance Authority (VMIA)-funded Intrapartum Fetal Surveillance Clinical Guideline, which ultimately led to the development of the highly successful Fetal Surveillance Education Program (FSEP), the successful collaboration with the Rural Doctors' Association of Australia (RDAA) and the Rural Doctors' Network (NSW) to secure Commonwealth government funding to enable the Specialist Obstetric Locum Scheme

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(now the Rural Obstetrics and Anaesthetic Locum Scheme), and the introduction and development of the workforce surveys into the coordinated collection of longitudinal data that is now undertaken annually by the College in relation to both Fellows and Diplomates. Valerie has made an enormous contribution to the College and on behalf of the Board, Council and other Fellows and Diplomates with whom she has worked, I wish to thank her for all that she has done in her time at the College. Her contributions will be recognised by the College through the presentation of the recently introduced College Distinguished Service Award during November Council Week following consideration of a recommendation in this regard by the College Honours Committee and the Board during July Council Week.

On the subject of Honours, I congratulate A/Prof John McBain, Prof Robert Norman, Winthrop Prof John Newnham and Prof Euan Wallace for the recognition of their contributions to women's health through their awards in the 2013 Queen's Birthday honours list.

In closing, as I prepare to take-up a new position, I would take this opportunity to thank all College members and others with whom I have had the pleasure of working during my time at the College, particularly during my time as CEO. My period with the College has been enormously rewarding and I truly wish the organisation every success as it enters the next phase of its evolution.

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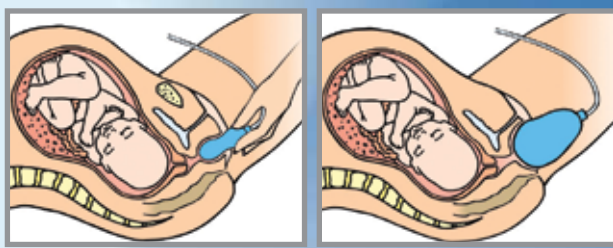
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Editorial



Dr Gillian Gibson
FRANZCOG

As a junior specialist, my feet hit the ground running with full-time work, on-call demands, a working husband and an 18-month-old toddler in tow. I thereafter experienced the regret of having left it too late as career opportunities took precedence over my biological clock. An increasing proportion of our Trainees are women. Long working hours and the pressure of examinations during six years of full-time training all too often coincide with our fertile years.

Family planning is important to Trainees of both genders as, increasingly, spouses are also in demanding work roles. Susan

Evans reflects back on life as a female O and G specialist, while Alex Mowat reviews the challenges of taking maternity leave while training. Achieving sufficient quality clinical exposure as Trainees, but working safer hours, is a modern-day challenge.

The College and the medical regulatory bodies face the realities of workforce feminisation, subspecialist training, distribution of specialists owing to geographical issues and urbanisation. In New Zealand, the contribution of specialist international medical graduates (SIMGs) and feminisation will shape the future workforce. There is

competition between a career in purely clinical practice and one dedicated to academic pursuit. Both Celia Devenish and Ian Symonds write about the personal and professional satisfaction to be gained from a career in academic O and G.

In the past decade, a resurgence of interest in O and G as a career choice has occurred, with applicants for Integrated Training Program (ITP) positions exceeding places available both in Australia and New Zealand. Jeff Taylor reports on the success of the Certificate of Women's Health in attracting Australian GPs back to postgraduate training – essential to maternity service delivery in remote and rural Australia.

Whetting the appetite of undergraduates to undertake the Diploma or specialist training is our collective responsibility as we encounter students in everyday work life. O and G presents an alluring mix of medicine and surgery in a relatively young healthy patient group. Alexa Bendall, DRANZCOG graduate and ITP Trainee, inspires with her experience of training in provincial Queensland

Nurture is defined as 'to care for and encourage growth or development'. This issue of *O&G Magazine* explores aspects of nurturing our workforce of obstetricians and gynaecologists. This is essential for the healthy future of the profession and the health of women in Australia and New Zealand.

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O and G is in our hands



Dr Andrew Pesce
FRANZCOG

'Not all of us can do great things. But we can do small things with great love.'
Mother Teresa

I graduated as a specialist obstetrician and gynaecologist in Australia in 1993. During my training and in the 20 years since, our specialty has always been either 'in crisis' or 'at the crossroads'. I recall times when it was difficult to encourage young doctors to choose to train in O and G as a result of a combination of medical indemnity problems and relative

underpayment for specialist services. Fortunately, it appears that there are enough young doctors who continue to want to train in the specialty, but it remains important to ensure that the profession is helped to adapt and flourish in a changing health system.

It is clear to all practitioners of our specialty that it comes under scrutiny more than most disciplines and to outsiders it would seem that we face many challenges in an evolving health system. The emergence of midwifery as an autonomous profession has brought with it associated challenges in defining the role of the obstetrician, in general, and also in individual practice. Whereas previously it was taken for granted that obstetricians were the clinicians assuming responsibility for pregnancy care, an increasing amount of that care is now provided by midwives. It might be easy to assume that with this shift there is a diminished importance of the obstetrician, but in reality the challenge lies in how obstetricians work with their colleagues. While still the backbone of maternity care in rural areas GPs have, for better or worse, ceased providing routine pregnancy care in

metropolitan areas, so referral to an obstetrician from a GP meant, in the large majority of cases, transfer of all care for the duration of the pregnancy and birth. In some instances care was shared, but there seemed little controversy regarding the roles of the collaborating doctors, who had absorbed the medical model of training and escalation to the specialist when necessary.

That model of care is gradually changing, with increasing focus from governments on midwifery primary care models, both in hospital maternity units and in private practice. At first this might seem a threat to our profession, but of course it is not. It is a challenge to us to continue to place women at the centre and focus of our work. I personally have seen these changes confirm how important the work of an obstetrician is to maintain a safe system of maternity care in Australia and New Zealand.

There remains another important issue that requires the attention of governments and RANZCOG. That is support for our rural colleagues. The issue of the difficulties faced by doctors in rural areas remains a huge challenge. It is not always clear how rural O and G practice can be best supported, but it is crucial that it is. In this area, it is clear that the role of the GP obstetrician will be fundamental in maintaining rural maternity services, and our representatives must support and augment efforts to develop the rural generalist pathways. It will be necessary to provide opportunities for those doctors who are working towards a rural career to obtain training and support from obstetricians in metropolitan hospitals, for at least some of their

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training, and support once they have entered the rural workforce. RANZCOG has been successful at such support in the past, but it is important that this effort continue and be expanded in the future.

What is required from us as individual specialists to nurture our profession in the future?

1. Take care to ensure medical students continue to receive appropriate exposure to obstetrics as undergraduates, especially in intrapartum obstetrics. It is very easy for medical students to be elbowed aside in birth units unless obstetricians and midwives positively support their education there. All specialists have an obligation to teach students. If you see an enthusiastic student, nurture this enthusiasm. Offer to call them for any births you are attending and, where appropriate, allow them to participate in the labour and birth. Maybe only one in 20 will embrace this opportunity, but they are gold for – and the future of – our profession.
2. Support vocational specialist training. RANZCOG does a good job in defining training requirements and balancing in its deliberations what is ideal for our Trainees and realities of maternity care systems. All specialists have an obligation to support specialist training. In my health district maternity service, there are 20 full-time midwifery educators to ensure midwives receive education and training. There are no full-time O and G educators. I am not lamenting this difference, but it is crucial that every specialist takes up the challenge of educating our Trainees. It is important to allow Trainees to perform as much surgery as they may perform safely under your supervision. When asked who will perform an operation by a patient (public or private) tell them all surgery is a team effort, with the senior and junior specialist required to perform various parts of the operation. Assure your patient that the senior specialist will perform any necessary surgery in the woman's interest, and allow the Trainee to perform as much as is safely possible under your supervision.
3. Participate in the numerous committees and meetings that underpin clinical governance of your unit. We lament when we are disengaged and not listened to by hospital administrators. The corollary must be that we positively engage and participate in the quality, safety and administrative functions of the hospital. I have seen too often that a significant proportion of consultant staff is content to leave this important work to a small number of usual suspects. Our Trainees are strongly influenced by the workplace culture they witness every day. It is crucial that all specialists accept the importance of involving themselves in the governance of their workplace.
4. Continue to support your colleagues. I believe this is done very well, by and large. Call for help when necessary and offer to assist, when possible, in difficult and stressful cases. There is nothing that helps the principal surgeon in a difficult case more than the reassuring presence of a second senior specialist, even if the second specialist is only assisting.
5. Be prepared to intervene when there is unacceptable behaviour. We usually give our colleagues the benefit of doubt when things don't go as they should. Most specialists will themselves change if they perceive disapproval from their colleagues. But in the rare instances of unacceptable behaviour, or when a pattern of unacceptable outcomes becomes manifest, use the appropriate mechanisms to report the clinician involved. I would have to say that this is the aspect of our professional lives that we do more poorly than any other, and when allowed to continue harms women, their babies, the institution, the profession and, ultimately, the offending individual.
6. Don't be a stick in the mud. The world is changing, as it always has. We don't practise in the same way as previous generations

of O and Gs did, and future generations won't practise as we do. Whether it will be because of a changing emphasis on work-life balance assumed by our younger specialists, or changing work patterns associated with newer models of care, be prepared to accept change and don't discourage innovative practice models when others develop them.

I have always considered O and G as the best job in the world. By nurturing the profession, we can ensure it always will be.

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Towards 2025



Dr Rupert Sherwood
FRANZCOG
Immediate Past President of
RANZCOG

The obstetrics and gynaecology workforce in Australia: factors shaping our future, and how we should respond.

If asked about 'workforce', many RANZCOG members and Trainees respond in numerical terms, perhaps adding some qualifiers on distribution, gender and age. Demographic changes, such as the preponderance of female Trainees, ageing of provincial Fellows and the urban concentration of our current Fellowship are well recognised, but difficult to quantify in terms of workforce supply.

Workforce supply-and-demand parameters are pivotal to those who are either established in practice, training to enter the discipline or at a pre-vocational stage contemplating a career in O and G.

Any discussion of the O and G workforce in Australia will have as many unknown as known factors. This is not say we, as a profession, should retreat from an informed and active participation in workforce planning in all forums. However, contemporary debate extends well beyond simple undergraduate or vocational Trainee numbers and now focuses on the 'training and vocational pipeline' – describing a continuum from medical school through pre-vocational and vocational training (including sub-specialisation), including career longevity and patterns of work throughout a career.

Taking into account recruitment from overseas (both temporary and permanent migration), changes in work practices, potential reforms to models of care that may reduce the demand for specialist and GP obstetricians, as well as predictions of expressed demand for services as the population grows and ages, we face a very complex system that starts to resemble one of Bruce Petty's legendary economic modelling cartoons of the 1980s.

In this short article I address some of the more relevant the issues affecting our workforce predictions over the next 12 years, with particular reference to the Health Workforce Australia (HWA) publication *Health Workforce 2025 (HW2025)* Volumes 1–3 with reference to p129–138 in Chapter 15, specifically dealing with the O and G workforce. The HWA documents and subsequent work plans outline the current and predicted scenarios as they relate to the various 'levers' of reform and change that might be enabled under the Federal Government's agenda.

At the time of publication of the HWA report, in October of 2012, the workforce was estimated to be in undersupply.¹ This formed the basis of the 'comparison scenario', (see 'terminology' below), under which we would remain under-supplied in 2025 by an estimated 142 specialists. Previous data collection and analysis by the Medical Training Review Panel (MTRP) have been more descriptive than predictive, but provided a valuable starting point for the HWA work.²

The MTRP was formed under legislation in 1996 to report to the Commonwealth Minister of Health on the activities of the MTRP and provide data on medical training opportunities in Australia.

Over the years the panel has aimed, through its annual report, to provide a comprehensive picture of medical education and training, supplementing this with other data on the medical workforce supply.

Internal RANZCOG data on Practice Profile³ and Trainee intent⁴ complement those data and predictions. The most recent Practice Profile data gathered by the College, from May this year, include responses within the last three years from over 70 per cent of the Fellowship and confirm the trends and predictions expressed in the HW2025 publication. The practice intentions survey of Trainees and recently elevated Fellows contains more subjective data, with information on the reasons why our Trainees and recent graduates choose various career paths.

To appreciate the findings and recommendations of the HWA data it is necessary to understand both the terminology and methodologies used in describing workforce. Additionally, limitations of data collection and analysis should be noted to qualify interpretation of those data and guide any revisions between now and 2025. That said, our specialty poses particular challenges for workforce modelling and predictions. Some, like the long lead-time from undergraduate to Fellowship (15 years at the earliest), are common to most disciplines. Others, such as the impact of the feminisation of the workforce, changes in the models of care in obstetrics and, perhaps most importantly, the lack of inclusion of deliveries managed by GP obstetricians in the HW2025, make application of the HWA Work Plan⁵ to our profession more problematic.

Additional limitations in the O and G workforce data used by HWA in its modelling for the 2025 report must be acknowledged and include:

- failure to model IVF separately, as this is a recognised high-growth area;
- lack of outpatient data for women's health (a limitation common to most disciplines modelled by HWA); and
- the likelihood that the reported working hours for in O and G includes significant 'on call' hours, leading to over-estimation of true 'time at work'. This may affect the 'expressed demand' calculations into the future.

Some specific terminologies are used when describing workforce parameters. These are described below in context with the Australian workforce and include:

- Comparison scenario – the 'do nothing' situation. This is an artificial construct used by analysts in which the current trends of demand, recruitment and migration are applied prospectively to the status quo in each profession.
- Expressed workforce demand – this important concept refers to predictions of the demand for services. There are several available methodologies for this indicator, with HWA adopting utilisation data that includes data on current services provided both in public (Diagnostic Related Groups and hospital separations) and private (Medicare data) sectors to predict future demand, taking into account predicted changes to disease burden, population and demographic changes. Expressed

demand is estimated to grow by 2.6 per cent per annum. Specifically identified limitations to this measure with respect to expressed demand for O and G are the lack of data from outpatient services and the failure to account for GP obstetric services. Of note is that demand for medical services per se does not directly translate to workforce demand. In addition, new technologies and ways of managing reproductive health issues will inevitably modify this parameter. The interested reader is referred to HW2025 Vol 3 p393–71 for a more detailed explanation of expressed demand calculations.

- Self-sufficiency: measuring the impact of increasing, maintaining or reducing reliance on overseas-trained doctors leads to an estimation of self-sufficiency for each profession. HWA has identified our specialty as one of the disciplines more heavily reliant on specialist international medical graduate (SIMG) intake than others. During 2010–11, more than 45 per cent of the new Fellows elevated to FRANZCOG were from overseas. This indicator is a part of the overall workforce 'vulnerability' (see below).
- Workforce vulnerability, referring to demographic factors such as age, gender and working hours, measures the ability of a profession to respond in a timely manner to changes in demand, either increases or decreases. Firstly, we are ageing and this, in combination with changing work practices (shorter hours, more part-time work and parental leave), means that those who replace the retiring Fellows may not provide equivalent 'supply' on the capacity side of the equation. The average age of specialist O and Gs in the 2009 Australian Institute of Health Workforce (AIHW) survey was 51 years, with 37 per cent of Fellows aged 55 and over. One-third was female, and in 2010–11 more than 45 per cent of Fellows elevated to FRANZCOG were from overseas.

Indicator	2012	2025
Average age		
Replacement rate		
Dependence on SIMGs		
Duration of training program		
Minimal concern for potential workforce impact		Significant concern for potential workforce impact

Figure 1. Summary of workforce dynamics indicators for O and G. © HWA 2012. Reproduced from Health Workforce 2025 Medical Specialties Vol 3 November 2012 with permission of Health Workforce Australia.

Scenario	2018 (Headcount)			2025 (Headcount)		
	Supply	Demand	Movement	Supply	Demand	Movement
Comparison	1,987	1,992	-5	2,180	2,322	-142
Service and workforce reform	1,987	1,791	196	2,180	1,959	221
Registrar work value	2,060	1,992	68	2,252	2,322	-70
Medium self-sufficiency	1,931	1,992	-61	2,020	2,322	-302
Capped working hours	1,875	1,992	-117	2,057	2,322	-265

Figure 2. Summary of workforce supply and demand projections for O and G. © HWA 2012. Reproduced from Health Workforce 2025 Medical Specialties Vol 3 November 2012 with permission of Health Workforce Australia.

- Dynamic indicators refer to additional inputs, such as length of training and ability to replace exiting workers.

In summary, our speciality is rated as 'vulnerable' with respect to age, dependence on SIMGs and length of training, with the first two of these to become more dominant by 2025.

Figure 1 (taken from HW2025) indicates the grading by HWA of the dynamic indicators, where we are placed in 2012 and predicted to be in 2025. As can be seen, only 'duration of training' will not increase in severity or impact in the interval 2012–25. What, then, are the levers that can be manipulated to achieve a positive balance to meet the predicted expressed demand over the next decade?

Figure 2 (HW2025 Vol 3) shows the predicted workforce effects in 2018 and 2025 of the different 'levers' that may be used to adjust supply, against predicted demand. Of particular note to Fellows of our College, the **only** proposed reform that produces a positive balance in workforce is 'service and workforce reform'.

Crucial to understanding and acting on the modelling by HWA for O and G workforce towards 2025 is an appreciation of the potential changes in the midwifery workforce with respect to the legislated (Maternity Reforms 2010)⁶ extended midwifery scope of practice, and the as-yet-to-be-modelled GP obstetrician contribution. With respect to the latter, very important challenges remain in both the training of GP obstetricians and providing ongoing support to these practitioners in often remote locations throughout Australia.

Lastly, we should examine how RANZCOG should respond to the workforce data, discussion and Health Department planning. Strategies could include:

- Proactive participation in discussions about productivity and efficiency, including new models of care. Ignoring the reality of work substitution, particularly in obstetrics, will likely result in our disenfranchisement from these reforms. Our College must continue to ensure that published data regarding better outcomes for women under specialist-led models of care are promoted and included in the reform agenda. As always, if we are not at the table, however disruptive to our work schedules this participation may be, we cannot object to the outcomes.
- Continue to make available, to HWA and the Commonwealth Health Department, the RANZCOG Practice Profile and practice intentions data, to ensure that policy decisions are informed, as far as is possible, by accurate and contemporary data.
- Request that any future modelling for the workforce takes into account GP obstetric contributions, particularly with respect to regional and rural expressed demand predictions.
- Continue to recognise and provide HWA with information

on important issues such as mal-distribution of workforce, Indigenous health disparity and changing healthcare technologies specific to our field.

- Provide our own expert commentary on demographic modelling with respect to the population seeking reproductive healthcare.
- Provide HWA and other reform authorities with realistic and pragmatic appraisals of the potential role of: simulation in training, competency-based assessment for reducing length of training, job substitution and the ability to use training settings outside the traditional public hospital model.
- Remain actively engaged in the SIMG discussion, particularly with respect to plans to 'streamline' IMG entry to medical practice, along with active promotion of opportunities in our and other specialties.
- Re-assess demand for additional vocational training places in light of predicted under-supply, cognisant of the capacity restraints that may not be readily acknowledged by workforce planners.

It is of paramount importance that we, as a profession, remain aware of the planned government response to the findings and predictions of HW2025. The vulnerabilities identified for our profession will mean that the reform agenda will be relevant to how we train, assess and manage our workforce.

The National Health Workforce Innovation and Reform Strategic Framework for Action 2011–2015⁷ has been approved by Health

Ministers and will guide the policy formulation that seeks to address workforce issues around key domains including:

- Workforce capacity – including training numbers, skilled migration (which may include further streamlining of pathways to specialist registration for those disciplines perceived to have a high reliance on SIMGs) and retention within the workforce.
- Productivity – contained within this 'reform' we see the changing of maternity models of care, and the concept of 'working to maximum license', a term that, in our speciality, refers to an extension of midwifery roles in maternity care. Cost efficiencies and building a role for clinical assistants are also part of this domain.
- Improving distribution – this refers to both geographical distribution and the balance between generalist and sub-specialist. For us, it is critical that the GP obstetrician workforce is accounted for in future planning (it was not included in HW2025), and that we maintain a focus on generalist O and G training. Fortunately, this has been acknowledged as the preferred direction for the Australian medical workforce.

Accepting that a continued dependence on SIMGs is likely under the HW2025 scenario, it is imperative that the College provides sufficient resources to maintain a transparent, equitable and appropriately validated assessment process to ensure that those SIMGs elevated to Fellowship meet the standards expected by both the public and jurisdictional employers. Unlike some previous reforms in maternity care, we have a place at the table for this work and both the National Medical Training Advisory Network (NMTAN) and HWA will be expecting an active input from the College in the discussions and future directions of any reforms to the training and 'vocational pipeline' for all the specialties, including our own.

In some respects, this article is a call to arms to the Fellowship to engage in medical workforce reform, lest we be sidelined in the name of efficiency and task substitution, to the detriment of the standard of reproductive healthcare delivered in Australia. Doing nothing, and assuming that the status quo will serve either our patients or our own professional needs, is not an option. A reform agenda that affects our profession throughout the entire 'pipeline' is underway and perhaps only those who have already packed their fishing gear and taken down the brass plate can afford to remain disinterested and detached from these issues.

Changes in population demographics and continued demands for high-standard healthcare are perhaps the most reliable predictions for the next decade – it is the training methods, assessment tools and the nature of care providers that will inevitably change. Our challenge as a profession, and in particular for RANZCOG as a professional standards body, is to stay engaged with the agents of reform and remain a major partner in how reproductive healthcare is provided to future generations.

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Workforce planning in NZ

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Factors of age, gender and nationality affect how many hours specialists work and how long they stay in the workforce.

There were 234 specialists registered in the vocation of obstetrics and gynaecology with the Medical Council of New Zealand (MCNZ) in 2011. Of these, 204 (87 per cent) contributed to the MCNZ workforce survey. This article is based on both the MCNZ data and the RANZCOG Practice Profile survey from 2012 (completed by 167 Fellows). International medical graduates (IMGs) make up 131 (56 per cent) of the New Zealand O and G specialist workforce. Some of these IMGs are members or Fellows of RANZCOG, the remainder are members or Fellows of their home colleges.

A survey of New Zealand District Health Boards (DHB) by our NZ committee executive officer revealed that there are currently 165 specialist O and G full-time equivalent (FTE) positions in New Zealand, with possibly another five FTE positions to be created by two DHBs. The difference between the number of specialists and the number of FTEs is accounted for by the 25 specialists in full-time private practice and the 110 specialists that do part-time private practice as well as some (numbers unknown) who choose to work part-time in the public system.

In New Zealand, 18–19 Integrated Training Program (ITP) Trainees have been appointed annually over the last two years to the 11 ITP rotations. The difference in numbers is accounted for by leave of various types, both temporary and permanent. Across Australia and New Zealand, 60 per cent of the ITP intake becomes Fellows annually, so we can expect to generate 11 new specialists per year or 55 new specialists every five years.

The age distribution of New Zealand O and G specialists from the 2005 and 2011 MCNZ workforce surveys is shown below (see Table 1 and Figure 3).

It can be seen that, within five years, six Fellows will be 75+, ten Fellows will be 70+, 23 Fellows will be 65+ and 39 Fellows will be 60+. The key questions are how many are going to retire and how many are going to reduce their hours and by how much?

We can get some insight from the Practice Profile, which states that 22 Fellows plan to cease private obstetrics during the next five years and 13 Fellows plan to cease public gynaecology within the next five years. It is likely, but not certain, more than 13 of the 39 Fellows aged 65 and over within the next five years will retire. If only 13 Fellows retired it would leave a depressing 42 of 55 new Fellows without employment.

There are, however, other factors that will see a greater number of Fellows required. The medical workforce is becoming feminised as well as ageing, and both female doctors and older doctors work fewer hours.

The MCNZ survey reveals, on average, in New Zealand, male doctors work 46 hours per week and female doctors work 39 hours per week. Currently, the majority of the medical workforce in New Zealand aged under 50 years is female and over 50 years is male. However, 73 per cent of our O and G Trainees and 41 per cent of our new Fellows in 2011 were female. Doctors in New Zealand work 40–43 hours a week until 65, when they reduce

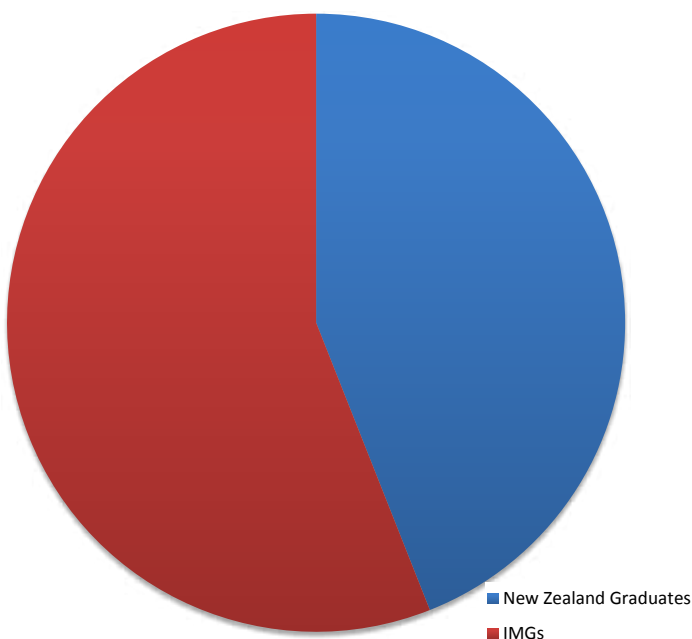


Figure 1. New Zealand O and G specialists by origin in 2011.

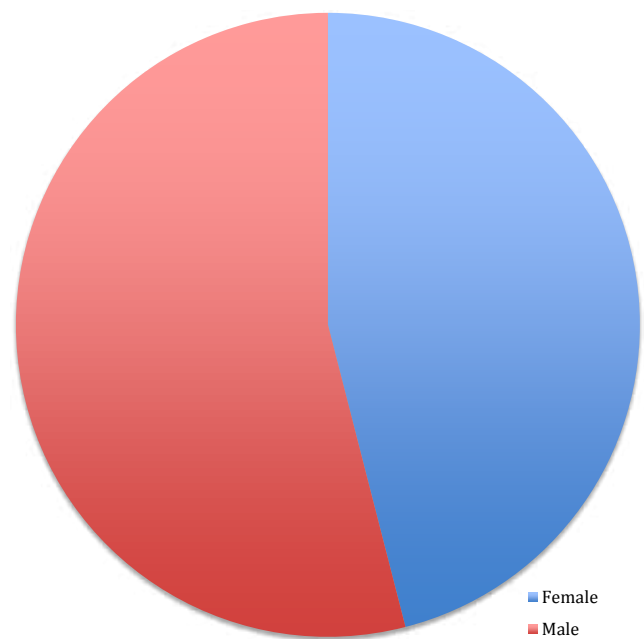


Figure 2. New Zealand O and G specialists by gender in 2011.

Table 1. Specialists: O and G as main work type by age group, 2005 and 2011.

Age range	<=24 No. % of total	25-29 No. % of total	30-34 No. % of total	35-39% No. % of total	40-44 No. % of total	45-49 No. % of total	50-54 No. % of total	55-59 No. % of total	60-64 No. % of total	65-69 No. % of total	70+ No. % of total	Total No. % of total
2005												
O&G	0 0%	0 0%	4 2.3%	17 9.9%	29 17%	46 26.9%	34 19.9%	22 12.9%	6 3.5%	12 7%	1 0.6%	171 100%
All work types	0 0%	3 0.1%	72 2.4%	371 12.6%	593 20.2%	676 23%	451 15.3%	346 11.8%	131 4.5%	131 4.5%	76 2.6%	2940 100%
2011												
O&G	0 0%	0 0%	1 0.5%	11 5.4%	31 15.2%	35 17.2%	48 23.5%	39 19.1%	23 11.3%	10 4.9%	6 2.9%	204 100%
Total	0 0%	7 0.2%	68 1.6%	516 12.3%	758 18.1%	736 17.6%	810 19.3%	547 13.1%	367 8.8%	249 5.9%	129 3.1%	4187 100%

Source: NCNZ Annual Workforce Surveys; response rates were approximately 91 per cent (2011) and 85 per cent (2005).

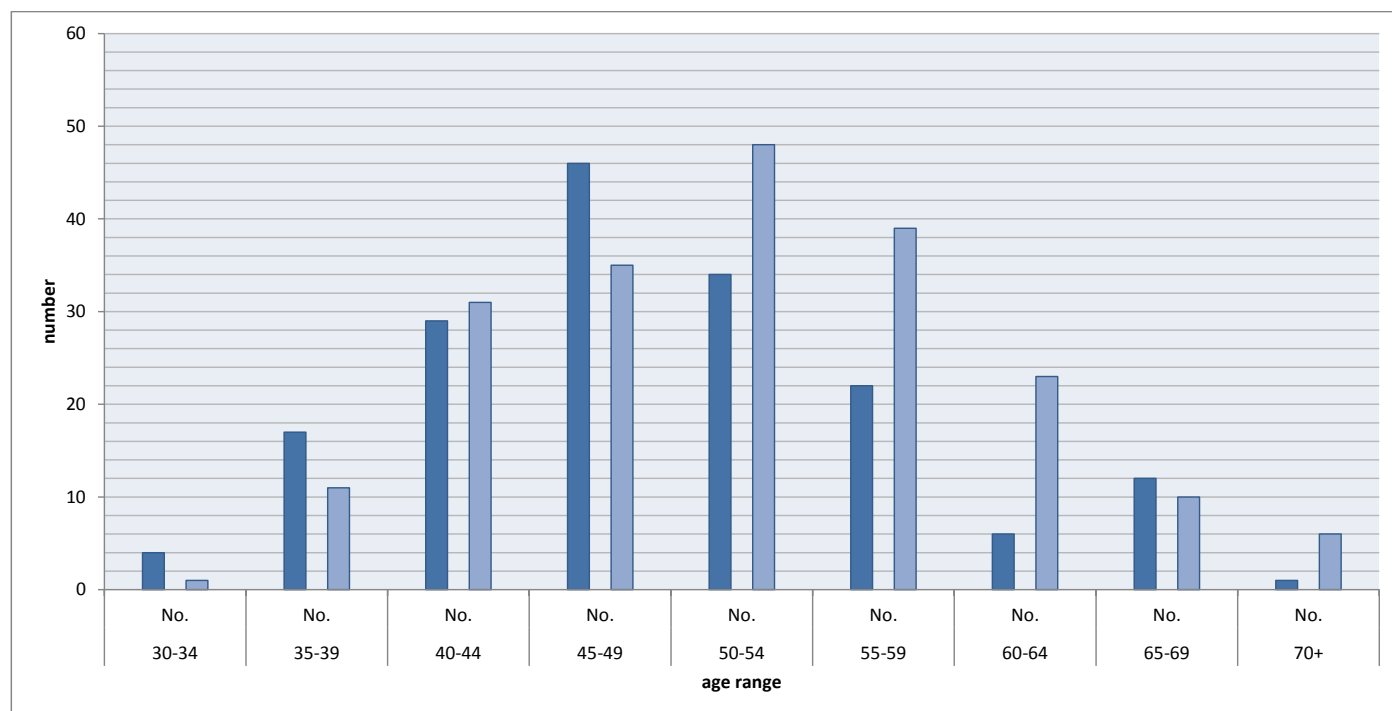


Figure 3. O and G specialists in New Zealand by age band 2005 dark, 2011 light.

to an average of 36 hours. At 70 the average is further reduced to 28 hours per week. The other trend noted is doctors are working fewer hours. In 2001, the average New Zealand specialist worked 49 hours per week; in 2011 they worked 45 hours per week (MCNZ 2011).¹

Although the percentage of doctors in New Zealand working after the age of 60 is decreasing, as the total number of doctors is increasing, the number of doctors in the five-year age bands progressing through the years from 2005 to 2011 does not decrease until age 70. This suggests that most doctors retire at around 70 years of age. However, within our specialty, looking at the 65–69-year-old cohort of 12 specialists in 2005, we can see that only six specialists are still working as 70+ year olds in 2011.

Assuming 165 FTE x 40 hours equals 6600 hours of public specialist O and G work per week across New Zealand's public

hospitals, we can see the influence of these various trends on the requirement for new Fellows within the next five years:

- We can expect the six Fellows aged 75+ to retire = 6 FTEs.
- Assuming seven of the ten 70+ year olds will have retired and the remaining three will work an average of 28 hours per week. $(7 \times 40 \text{ hours} + 3 \times 28 \text{ hours})/40 = 7.9 \text{ FTEs}$.
- Assuming half of the 23 65–69 year olds retire and the other half reduce their hours to 36 hours a week then $(11.5 \times 40 \text{ hours} + 11.5 \times 36 \text{ hours})/40 = 12.65 \text{ FTEs}$.
- Assuming average hours worked per doctor decrease by another two hours over the next five years $(165 \times 2 \text{ hours})/40 = 8.25 \text{ FTEs}$.
- Assuming the feminisation of the specialist workforce increases to 73 per cent from the current 41 per cent and that those specialists work on average six hours a week less than their male counterparts, then $(165 \times 0.73 - 165 \times 0.41) \times 6 \text{ hours} = 312 \text{ hours}/40 = 7.8 \text{ FTEs}$.

This combination of retirees and decrease in working hours gives a total of 42.6 FTE positions becoming available for the 55 new Fellows predicted.

However, before the Trainees become too despondent, the forgotten factor is that 56 per cent of the New Zealand specialist O and G workforce are IMGs. According to the 2011 MCNZ workforce survey, 25 per cent of vocationally registered IMGs leave the New Zealand register within five years of gaining vocational registration: $234 \text{ specialists} \times 0.56 \times 0.25 = 32 \text{ FTEs}$.

This gives a total of 74.6 new FTEs being required over the next five years when we expect 55 Trainees to become Fellows. Clearly, then, there is still a need for IMGs.

In five to ten years' time, there will be 39 specialists in the 65–69 age group and 48 specialists in the retirement age group.

The dynamics of specialist O and G immigration and emigration as well as per cent FTE or hours worked by individual specialists will need to be monitored. As the locally trained workforce increases then the FTE created by departing IMGs will diminish over time and thus fewer new FTE positions will be available.

In the future, we may need to employ some IMGs on the registrar roster as non-training registrars and limit ITP training posts and if we wish to balance workforce requirements with Trainee numbers.

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Acknowledgement

Thanks to Robert Hipkiss at the Ministry of Health for extracting the specialist O and G workforce data from the 2005 and 2011 MCNZ workforce surveys.

Cairns and Hinterland Hospital and Health Service



Hospital and Health Service Clinical Director of Obstetrics and Gynaecology

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Lost, but not alone, in the labyrinth

Dr Chris Hughes
FRANZCOG
Chair, Specialist IMG Assessment
Committee

RANZCOG and specialist international medical graduates – what progress has been made?

Dr Sarah Tout
FRANZCOG
RANZCOG Vice President

Lyn Johnson
Director of Education and Training

A previous article in *O&G Magazine* (Winter 2011, p74–76) described the processes by which international medical graduates (IMGs) with specialist qualifications obtained in countries other than Australia or New Zealand are assessed for comparability/equivalence to an Australian- or New Zealand-trained specialist.

The similarities and differences of the processes in both countries were described, along with an outline of considerations that need to be taken into account by the College when undertaking such assessments. The article acknowledged the complexity associated with this aspect of College activity and made reference to the Australian House of Representatives inquiry into overseas trained doctors that had yet to report at that time.

The report of that inquiry, titled 'Lost in the Labyrinth', was handed down in March 2012 and contained 45 recommendations intended to improve the efficiency and transparency of processes associated with the assessment and registration of IMGs (both specialist and non-specialist) in Australia. The report may be accessed online at: www.aph.gov.au/parliamentary_business/committees/house_of_representatives_committees?url=haa/overseasdoctors/report.htm.

Part of the committee's deliberations related to 'the provision of professional and personal supports for IMGs and their families', writing that 'access to these types of supports is not only crucial to the initial recruitment of IMGs, but also to rates of retention', and noting: 'The committee's recommendations seek to enhance and strengthen existing systems of support, including pre- and post-arrival orientation, access to professional development opportunities and peer support networks for IMGs, and access support networks for spouses and children.' Further, the report made the point that: 'in formulating the report's 45 recommendations the fundamental aim has been to reduce red tape, duplication and administrative hurdles faced by IMGs, whilst ensuring that the Australian standard [of healthcare] continues to be applied.'

Of the 45 recommendations, a number applied to issues relating to IMGs seeking general registration, while others applied only to those seeking specialist registration, with some having applicability to both groups. Similarly, some recommendations had direct relevance to the specialist colleges, either solely or in conjunction with other bodies, such as the Medical Board of Australia (MBA), the Australian Medical Council (AMC) and Health Workforce Australia (HWA).

To this end, following the release of the report, a working group involving representatives from the MBA, AMC and the Committee of Presidents of Medical Colleges (CPMC) was convened to examine the recommendations and respond to government in relation to way(s) in which relevant aspects of the assessment and registration of IMGs seeking specialist recognition could be improved. One significant outcome of the activity of the working group was a recommended set of refinements to the processes associated with the overall specialist comparability assessment, which should result in a reduction of administration requirements through a streamlining of the application process, including the manner in which documentation is received and distributed, in order to enable the different parts of the overall process to occur as efficiently as possible.

A number of recommendations contained within the Lost in the Labyrinth report relate to support for IMGs, particularly in relation to orientation within the Australian healthcare system, as well as the provision of adequate, appropriate clinical supervision placements. Both of these aspects are high on the list of College priorities of mechanisms to assist IMGs working towards College Fellowship, and much has been done over time to provide appropriate, high-quality online materials to assist the former. All applicants for specialist IMG (SIMG) assessment who are determined as being eligible to progress to the interview phase of the assessment process are provided with a personal login that enables access to all materials available to RANZCOG ITP Trainees, including the full suite of CLIMATE education modules.

For SIMG applicants assessed as partially comparable to an Australian-trained specialist, as part of the Commonwealth's Specialist Training Program, funding has been made available through the College to assist with attending courses and workshops that are identified as being able to help individuals to address identified upskilling needs. Such needs are identified during assessment by the College, as well as through consultation between the partially comparable SIMG and their Training Supervisors. The College SIMG Training Portfolio can be used to match upskilling needs with resources, with approved funding able to be used for training (workshops, seminars, clinical training and so forth) and associated travel and accommodation costs. Further information in relation to this funding initiative may be found on the College website at: www.ranzcog.edu.au/partially-comparable/additional-information/funded-training.html. Workshops offered by the

College and tailored to assist SIMGs as they work toward their Fellowship, include An Introduction to the Australian Health Care System and Effective Communication Skills.

Factors surrounding the securing of suitable sites with appropriate oversight or supervision and training/upskilling to ensure SIMGs meet the requirements necessary for recognition as a specialist in obstetrics and gynaecology in either Australia or New Zealand are not simple. In neither country is the College an employer of medical workforce, nor does it have a role specifically in acting as an intermediary between employers and individuals seeking to obtain employment that will offer the necessary clinical (and non-clinical) opportunities that may be required. The situation is further complicated in Australia by the existence of Federal and State workforce initiatives designed to address workforce shortages through Area of Need and Districts of Workforce Shortage identification, and in New Zealand where applicants for SIMG assessment may be employed in positions requiring a range of skills over and above that held by the practitioner prior to their assessment by the College in its role as a Branch Advisory Body for the Medical Council of New Zealand.

The Lost in the Labyrinth report contained multiple recommendations in relation to the areas of orientation and supervision of SIMG applicants and the reference to recommended collaboration between multiple stakeholders illustrates both the importance of this matter, as well as the complexity. The long-held view of the importance of ensuring the least prepared individuals do not get placed in the least supported and potentially clinically high-risk environments seems to have been voiced to and heeded by the committee, and the College seeks to ensure that appropriate supervision arrangements that will support both the SIMGs whom it has assessed and the communities that they serve are in place for all individuals.

The awareness that this extends to the training and support of those responsible for supervision and/or oversight requirements is also understood and the College is constantly looking for ways in which to improve aspects of the process applicable to these individuals, including the provision of College workshops to address the specific needs of the people undertaking these roles.

The above notwithstanding, the College, through the SIMG Assessment Committee, is aware of the need to continue to improve the support mechanisms provided to IMGs seeking recognition as specialists in O and G, and who are progressing to that status following assessment by the College. Much has been accomplished in recent years to align processes used by the College across the two countries it serves, as well as to ensure that thorough, accurate information is available to potential applicants, including in relation to the fees associated with the assessment processes and the ability to request reconsideration, review and appeal of College decisions. Assessment processes have been refined and significantly altered to ensure that requirements reflect the variable experiences and capacities of individual practitioners, as well as ensuring that candidates are given the opportunity to demonstrate the breadth, depth and range of their training and experiences, and the move toward workplace-based assessment methodologies is clear.

On an overall basis, both Australia and New Zealand have a significant proportion of IMGs in the workforce that delivers medical services, particularly in the regions that may be considered rural or remote. The extent to which this reliance may be lessened in the future through government initiatives in either country, is, at this

point, unknown. Indeed, both countries are training more medical graduates (albeit to differing extents), and these increased numbers of locally trained primary medical graduates can logically be expected to lead to increased numbers of locally trained specialists, with possible pressures resulting that may see changes in workforce distribution of locally trained specialists, in addition to changes simply in workforce numbers.

The College is aware of the importance of both specialist and general registration IMGs to the medical workforce of Australia and New Zealand, and the associated importance of ensuring the nurturing and support of these individuals to ensure they are able to practise in a clinical environment where they are supported both professionally and personally in a manner that enables the delivery of women's healthcare to the standard expected by the communities of Australia and New Zealand. All aspects of all programs offered by the College are constantly examined to determine ways in which they can be improved for users, and the assessment and training programs offered by the College in relation to SIMGs are no exception.

While no one would claim that all that is able to be done has been done, the College has made significant commitment and progress over time to ensuring that it is aware of all developments that affect this area of its functions, and to adjust processes and requirements to reflect this, and will continue to do so. This includes working with government and other stakeholders, as well as being proactive to ensure that internally initiated improvements in relation to this group of practitioners continue to be made.



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Safe working hours and surgical training



Dr Michelle Harris
CGO Trainee

Learning to be a surgeon is similar to learning to play an instrument: talent is moulded by focused teaching, many hours of thoughtful practice, performance review, observation of peers and refinement of skills. It is crucial that reduced working hours for surgical Trainees do not negatively impact on this process.

Three years ago, when I was a fifth-year Trainee, I was involved in a robust discussion with colleagues about the impact of safe working hours on FRANZCOG training. I argued that the term was misleading – while reduced working hours may lead to less fatigue, it

would also lead to less training time and potentially to specialists who were less skilled and therefore less safe than those who had worked longer training hours. It was a corridor discussion, and I thought little more of it, until one of those colleagues contacted me recently to ask me to write an article on the topic. Ironically, when she called I was working in a position formerly held by two full-time doctors. I was regularly at work 80–100 hours per week, continually first on-call for my unit, and this situation had been sustained for 12 months. I could barely remember the conversation, let alone identify with my previous conviction that reduced working hours were a negative imposition on medical trainees.

Across Europe and the USA, as well as in Australia, there has been a strong push over the last two decades to reduce the number of hours worked by doctors. This has been with the aim of improving patient safety, but also the health and well-being of doctors. These reductions have been legislated in parts of North America (Code 405, ACGME National Guidelines)^{1,2,3} and the UK/Europe (New Deal⁴, European Working Time Directive⁵). Although there is no such legislation in Australia, the Australian Medical Association (AMA) has been a powerful advocate for reduced working hours for doctors through their Safe Hours Audits of 2001, 2006 and 2011, and the voluntary Code of Practice – Hours of Work, Shiftwork and Rostering for Hospital Doctors.⁶

There is a significant body of evidence on the effects of fatigue on motor skills and judgment.^{7,8,9} Clearly, prevention of levels of fatigue that impair doctors' skills and put patients at risk is crucial. This involves management of the roster patterns, as well as the number of hours worked. It is a complex issue, however, as the circadian rhythm disruption of shiftwork can potentially cause more fatigue than traditional on-call rostering.¹⁰ It is recognised that there is variation on how roster patterns and accumulated sleep debt affect different individuals and to what degree this causes impairment in those practitioners with differing levels of experience. Concerns have also been expressed that the improvement in patient safety that may be gained by shorter shifts is partly negated by the decreased continuity in patient care.¹¹

More recent literature on reduced working hours for doctors investigates the implications for medical training and, in particular,

surgical training. The European Working Time Directive (EWTD) introduced an average 58-hour working week in 2004, moving to 56 hours in 2007 and 48 hours in 2009. The Association of Surgeons in Training (UK) strongly expressed concern about the training effects of the EWTD in a number of publications, including a position statement¹² and an editorial in the *International Journal of Surgery*.¹³ These documents refer to a number of studies that demonstrate a specific reduction in surgical training opportunities since the introduction of the EWTD. The Section of Surgery of the European Union of Medical Specialists published a position statement stating that the EWTD is: 'in direct and severe conflict with former EU legislation to train competent surgical specialists.'¹⁴ One of the papers sometimes quoted to justify the position that reduced working hours do not adversely affect postgraduate medical training is a systematic review of 72 studies on reduced hours and outcomes, published in 2011 in the *BMJ*.¹⁵ The only conclusion from this analysis is that reducing working hours to less than 80 per week has not adversely affected outcomes for patients or postgraduate training in the USA. It is an interesting report to read in its entirety, though no conclusions could be drawn about the impact of reducing working hours to less than 56 or 48 hours per week, owing to conflicting results across institutions and specialties.

Studies and comments that compare doctors' working hours with those of professional groups such as aircraft pilots can underestimate the importance of other aspects of training. It is true that both pilots and doctors are in a position of responsibility for others and at times will need to make life-and-death decisions in an instant. Both groups are also susceptible to fatigue, which may impair performance. However, this is not the whole picture. Becoming a gynaecological surgeon involves dexterous development under the guidance of a master teacher. In this way it is more similar to learning to play a musical instrument at a high level: a technical foundation is secured initially, followed by many hours of regular practice, ongoing supervision from an interested expert and continual refinement of skills. As with musicians rehearsing a new piece of music, mindless repetition of entire procedures doesn't improve skill efficiently. A procedure can be broken down into specific elements, which are then practised until they are mastered. In many cases, this practice may be achieved in a simulated setting. Critical evaluation of performance is also crucial for both musicians and surgeons. Recording of Trainees' procedures, both laparoscopic and open, is a useful and efficient training technique to achieve this.

The reduction of doctors' working hours addresses risk associated with fatigue, but if introduced without specific attention to the subtlety of what makes a surgeon, then risk associated with lack of training may be increased. Prof Sir John Temple undertook a review of the impact of the EWTD on the quality of training.¹⁶ He makes the

point that traditional models of training and service delivery in the setting of reduced hours dilute the quality and quantity of training, and waste learning opportunities. 'Make every moment count' is a phrase coined in relation to optimising the learning opportunity in every clinical situation encountered. A multidisciplinary approach is recommended to reduce unnecessary and non-training demands on junior doctors, by developing the roles of specialist nurses and surgical care assistants. Recognising and rewarding trainers is another recommendation of the review.

The Qualitative Research Report for the UK's General Medical Council by Morrow et al¹⁷ further explores the impact of reduced working hours on medical training and adds support for implementing the recommendations of the Temple Review. 'Education and training should be placed at the heart of service delivery,' the report emphasises. While most respondents saw the long working hours of the past as counterproductive, simply reducing hours without a significant change to the educational component of their work added new stressors to training doctors.

It is difficult to take advantage of learning opportunities when exhausted and a return to the >80-hour working week is neither likely nor desirable. An Australian and New Zealand survey of surgical Trainees concluded that 55–60 hours per week was appropriate for balancing surgical training and fatigue risk.¹⁸ Work hours should not be considered in isolation, however. A package of changes needs to be introduced within a reduced working hours framework – attention to roster patterns, a multidisciplinary approach to non-training duties, prioritisation and integration of training into the working day, and maximisation of innovative educational techniques and opportunities. Trainers and Trainees should be actively involved in these changes, rather than passively accepting rosters which potentially impede good training and the development of clinical excellence.

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VOLUNTEER OBSTETRICIANS NEEDED IN ETHIOPIA

Up to one in 16 women are dying from pregnancy and related conditions during their lifetimes in sub-Saharan Africa. Almost all of these deaths can be prevented. Ethiopia accounts for more maternal deaths than any other country in the region.

Dr Andrew Browning, currently resident in Tanzania, is seeking volunteer qualified obstetricians and midwives to work in regional hospitals in Ethiopia.

One such hospital is in a town called Barhir Dar in Northern Ethiopia. It seeks to serve the millions of women who cannot afford basic maternity care in the government hospitals.

The volunteers will have the chance to impact on the lives of women and their families in a very real way and also to train the local health staff in emergency obstetric care.

For queries contact:

Dr Andrew Browning

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Everyday academia



Dr Celia Devenish
FRANZCOG

'Teaching is about igniting the mind rather than filling it up with information.'
Plutarch

Trainees are expected to be well versed in critical appraisal and good research methodology, including audit. They look to us for assistance. How can we help them, our patients and ourselves?

For some 'academic' sounds irrelevant and dry, but I would like to suggest quite the contrary: it can be refreshing, exciting even fun to challenge or justify what we do, and why we do it. 'Academic' can also refer to a systematic way of learning to think and question, rather than just what to know. It is training the brain to look for new strategies to manage complex questions. Sometimes it is just recognising the obvious. I have listed academic opportunities available in every unit anywhere at the end of this article.

Reflecting on objective information, to my mind the cornerstone of academic procedure, provides a strong foundation for good clinical practice. Best practice must be a flexible dynamic process, able to change as evidence and understanding evolve. Far from receiving the wooden spoon from the Cochrane Committee, as at its inception, our specialty now leads the way in providing an evidence-based approach to clinical care.

From 2014, there will be an academic pathway to Fellowship that encompasses a PhD, using a part of advanced training time from the outset of training. Research, both clinical and purely scientific, is about looking for relevant information to inform best practice and seeking new understanding of age-old problems.

Sharing knowledge and disseminating facts and conclusions is a core responsibility of all practitioners. This goes beyond formal teaching; it encompasses the everyday ward round and handover.

'I believe that success in teaching is when one person follows a career choice because you made a difference to their learning.'

Nurturing the future of O and G is also about enhancing learning experiences in the discipline, enabling the acquisition of new skills and questioning why and what we do. Moreover, it requires that we are willing to change ourselves and our practice in response to new information.

Case study: Karyn Anderson

'As a fourth-year medical student, my introduction to research was positive. Over the 2010–11 summer break, I undertook a research scholarship, investigating the effects of maternal smoking on the developing placenta. This gave me clinical exposure to pregnant and labouring women and database experience. This research was subsequently accepted for a poster presentation at the 2011 RANZCOG Annual Scientific Meeting (ASM) in Melbourne, alongside approximately 60 other posters from Trainees and Fellows.

For me, the conference theme: 'Today's science; tomorrow's practice' was pivotal. My research studentship changed into a passion for clinical practice of obstetrics and gynaecology and the desire to one day make this a reality.

It is hard to believe I boarded my plane to the Australian conference with feelings of trepidation. I was asking myself: was I making a mistake? Would I even understand what they were talking about? However, I need not have worried as I was greeted with the same warmth and sense of collegiality as the Trainees and Fellows attending. At the conference I learned about a range of topics and current updates and controversies. I would strongly encourage every medical student to participate in projects and submit to conferences while they are still at medical school to develop a greater appreciation of the medical specialties.'



Karyn Anderson and Dr Rupert Sherwood, then President of RANZCOG, at the 2011 ASM held in Melbourne. Karyn presented her poster on the effects of maternal smoking on the placenta at the ASM. Karyn is currently completing her Trainee intern year.

Audit as a learning tool

Audit is about determining and ensuring best clinical practice and should not be viewed as a chore. Rather, it should be seen as a dynamic process enabling best care. It indicates where changes should be made and then measures the effectiveness of those changes. This can have a real impact on women's experience of care. A recent audit of emergency department gynaecology visits showed an increase in referrals to the department after pregnancy termination following introduction of a medical termination option. It transpired that this was because GPs had not been educated about the expectations from the medical process. Without audit no one would have known there was a problem. Similarly, a vaginal birth after caesarean (VBAC) audit showed that once a VBAC choice was made, the outcomes were successful, but numbers were limited at point of entry due to inconsistent information provided within the unit. This was corrected by reaching a consensus statement within the unit and education evenings for parents. Uptake is now more appropriate.

Case study: Flora Kwon

'At the end of fourth year I took the opportunity to do a summer research project, looking at correlation between clinical obstetrics and placental pathological findings in pregnant diabetic women. This is a current topic of increasing interest, aiming to identify biochemical markers hypoxia and prediction of pregnancy problems. I met women at the diabetic antenatal clinics and during their hospital admissions and collected their placentas. Women with a BMI of over 39 were also recruited. A database of their pregnancies and outcomes was created and compared with their placental pathology. I learned to prepare slides from the placenta, with our pathologist co-researcher. We reviewed macroscopic, microscopic and histo-biochemical changes. I gained insight into clinical risks of both diabetes and obesity during pregnancy.

'I was able to present this project at the New Zealand ASM in Napier this year. Many clinicians approached me with interest and support for my presentation even though I was only a student.

'My interest and passion for obstetrics and gynaecology has become much stronger. I hope to be involved with further projects in and to learn more in this field. I am very grateful for my amazing experience.'

Encouraging students

How as academics do we best nurture young professionals into their future career? The enthusiasm and sincerity of a role model are clearly important, as is their willingness to give time and to share their knowledge.

Studies suggest medical students are most open to making career choices in their early clinical attachments. Summer student projects provide a way of viewing the discipline in a more relaxed manner

Case study: Dr Kate van Harselaar Year 4 Trainee

'My first academic research experience was a master's degree before commencing Integrated Training Program (ITP) training.

'The beginning and the end of any research project tend to be the most gruelling parts. Any research requires ethical approval, so this needs to be done before your research can start. Obtaining ethical approval can be challenging, but there are many benefits to it. By the time you've ticked all the boxes you truly understand what you're doing and why you're doing it. The process helps you iron out any weaknesses that might be present from risks to participants, number of participants needed to achieve an adequate power of the study, inclusion and exclusion criteria, funding and the need for Maori consultation. The final stages of writing up are also a challenge. The critical thinking acquired during this process is a great recompense for the time invested. I have just completed another ethics application as part of my elective year project.

'Research is also an essential part of our everyday clinical practice, as all our clinical decisions should be evidence based. For those that don't have an interest, try it, there are many hidden rewards.

The RANZCOG ITP training program offers many avenues for research. These can be projects, publications, registrar presentations for an ASM or even a PhD through the academic stream. All ITP Trainees need to undertake a research program. For many trainees this provides an opportunity to trial research for the first time.'



Flora Kwon, RANZCOG CEO Dr Peter White and President Prof Michael Permezel at the New Zealand ASM held in Napier, earlier this year.



Dr Kate van Harselaar at College House in Melbourne.

without the time pressures of a run. It is also an opportunity to really see how specialists work and behave.

A student's innate empathy or aptitude for obstetrics, surgery or fetal medicine can be ignited by a case experience. The sense of being valued and respected by the speciality team, involvement in patient care and responsibility are all essential factors. Making time for students to assist or perform simple procedures is also greatly valued, especially when abundant patience and a sense of humour accompany the exercise. Teaching others is also part of the professional responsibilities of any Fellow.

There are many ways we can nurture our future specialists. Our College provides all Fellows with wide opportunities to assist our future specialty while updating our own skills at the same time.

What can you do now?

Aside from research, there are many ways of assisting with our juniors' academic needs with regard to audit and teaching. Furthermore, Medical Councils now expect medical practitioners to participate in audit as terms for registration. Your participation in any of the following will help current Trainees and those yet to start training:

- Create or participate in a guidelines group. It is also in our own interest to reflect critically on how protocols and guidelines are followed and other quality issues.
- Assist junior staff with local surgical audits for mutual benefit.
- Submit a poster to an ASM or regional meeting.
- Complete a practice audit. Audit templates are available through the College website. C-QulP also expects audit of outcomes in colposcopy. CPD points are available and increasingly the expectation is that all specialists are involved in some form of practice audit.
- Get involved with undergraduate teaching. This is increasingly less formal and looks to both provincial and private sectors for wider clinical experience for increasing student numbers.
- Get involved with Diploma and Certificate teaching and supervision. Increasing postgraduate year 1 and 2 interest in postgraduate training supervision translates to a greater demand for teachers with clinical experience to act as supervisors and tutors.
- Provide RANZCOG pre-training registrars with practical support with their learning and applications.
- Hospital-based clinical competencies and assessments, such as

OSATS, are likely to increase – read up on them and be willing to offer training opportunities.

- Training supervisors are often in short supply. Irrespective, attend a training supervisor workshop to better understand Trainees' needs. They are gratis!
- Apply to be a RANZCOG examiner. Examining for written and oral Membership and Diploma examinations provides all-important opportunities that enhance current knowledge.
- Make yourself available for mock exams or courses for Membership exams through your regional Training Accreditation Committee.
- Encourage your unit's participation in multicentre randomised controlled trials such as the current Magenta and APPTS. Postgraduate research is a possibility for us all.
- Undertake a Cochrane Review. Cochrane Reviews are within the capacity of any Fellow whatever their role or circumstances. They can be focused on an area of interest or relevance.
- Allow insight into real-life O and G. Even a remote Provincial Fellow or urban private practice can offer a summer studentship to a medical student to look at, say, audit of rural transfers, normal births or community outreach programs, using any clinical indicator.
- Create learning opportunities through inter-departmental meetings to present and discuss cases of mutual interest with ultrasonographers, midwives, paediatricians, emergency department staff, physicians, GPs and/or the ICU team.
- Instigate teaching topics in your region open to all health practitioners on anything from 'ovary' to 'fetal abnormality' It is surprising how much pooled learning and discussion there can be.
- Run in-house emergency drills with midwives and emergency department rural hospital transfer staff. Just practising makes for better communication.
- Become a PROMPT, ALSO or MOET instructor.
- Teach and lead critical appraisal of journal articles. Use a template such as 'GATE'. Practice makes perfect.
- Start a fund for a Pacific island exchange experience for a student or doctor, work with the College's Asia Pacific Committee.
- Offer your services as a volunteer through RANZCOG and take a student or Trainee with you.
- Invite a visiting expert to share current knowledge or research. Universities have lists of overseas visitors.
- Create a current research board for local awareness. Provide information and landmark articles – your own or others.
- Create an Advanced Year 5 and 6 training position in your unit that offers teaching or research opportunities.
- Offer assistance with an interesting case report or write one yourself.
- Create a local fund for research using charity sources, such as the lotto or bequests.
- Enrol in postgraduate classes in medical education, distance teaching or statistics.
- Explore the RANZCOG interactive program for teaching supervisors on CLIMATE. It is appropriate to all Fellows.

Have you changed your address or email account recently?

Have you notified the College of these changes?

If not, please update your contact details via the RANZCOG website (www.ranzcog.edu.au) and follow the link to 'Update contact details' or call 03 9417 1699 to notify the College of your changed contact details.

I believe that success in teaching is when one person follows a career choice because you made a difference to their learning. We are in charge of the profession's future and there is an academic within us all. I challenge every reader to consider participating in just one additional activity from the above as your means of the nurturing the future. What are we waiting for?

Why be an academic?



Prof Ian Symonds
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The challenges of an academic career seem to be better known about than the rewards. This article tries to redress the balance.

Australia and New Zealand (ANZ) have an outstanding record in research and medical education in reproductive health, but we struggle to interest Trainees to enter academic careers in O and G. The lack of suitable ANZ-trained academics has forced universities to recruit from overseas (luckily for some of us).

What is an academic?

Generally, an academic is someone who holds a university

appointment on a full- or part-time basis. Typically, a clinical academic will also hold a part-time appointment with a public hospital and may also run their own private practice. Honorary academic titles are also conferred by universities on clinicians who are employed on a full-time basis by a local health district. The university may then 'buy back' part of that person's time for teaching and research. Having such an adjunct appointment does not necessarily mean these academics are any less involved in research or teaching.

Generally, the career path in academia starts with a research higher degree then appointment at lecturer level progressing to senior lecturer, associate professor and then full professor. Career progression is not related to length of service, but to achievement in research, teaching and leadership. The balance between these areas often varies over a career and between individuals. Some academics will have a research-only role, but even here they are expected to provide training and mentorship to early-career researchers. Some academics will have a large teaching role, but will still be expected to publish and engage in scholarship of some form (for example, in curriculum development).

What are the sacrifices?

The main drawback to a career in academia is the additional time needed to complete training. A research higher degree (usually a PhD or MD) is essential, which means taking time out from

clinical training to do this. This can take three years or more on a full-time basis, longer if part-time. The new academic pathway introduced by the College will make this easier by reducing the length of clinical training for academics to five years and by extending the maximum time in program by three calendar years. Building a profile as a researcher is essential for attracting funding and for promotion. This means travelling to present your work at conferences. On the face of it this might not seem such a 'sacrifice', but it does make running a private practice difficult and means being away from family. Academics have fewer fixed commitments so are often in a position to undertake administrative and leadership roles within their discipline groups or clinical services. At the same time, they still have to meet performance targets for teaching and publication and what happens, in practice, is that much of this work gets done at weekends and evenings, further impinging on personal and family time.

What are the challenges?

Clinical academics need to maintain their clinical skills – a particular challenge for a procedural speciality such as ours – at the same time as competing for research funding with 'full-time' scientists. External grant funding is highly competitive with less than 20 per cent of applications for project funding to the National Health and Medical Research Council (NHMRC), the main funding body for medical research in Australia, being successful. Teaching loads can be significant and although responsibility for face-to-face teaching is shared with colleagues, academics are expected by medical schools to be responsible for course coordination, assessment and student welfare. Both teaching and research governance have become increasingly complex and time consuming in recent years.

What are the rewards?

If you are interested in financial rewards as the main benefit of an academic career, you should probably stop reading now! The rewards of an academic career are more in terms of personal and professional satisfaction. There are opportunities to travel, to meet and work with colleagues from around the world, and, through the results of your research or leadership, to influence the future direction of the speciality. No two weeks are the same. You have the immediate satisfaction of being able to practise your craft as a

Box 1. College initiatives to support academic development

- The encouragement of applications into the training program from Trainees with proven academic ability, by recognition of previous academic achievement in the selection process.
- Support for research by funding through the RANZCOG Research Foundation.
- Including key learning outcomes in teaching and research in the curriculum for all Trainees.
- The inclusion of a mandatory research project as part of the FRANZCOG requirement for all Trainees.
- The development of learning materials, such as the research methods and supervision training modules available as part of CLIMATE, for Trainees.
- The development of training modules in medical education and research for the Advanced Trainees.
- The option for Trainees to take up to three additional years to complete a research higher degree at Doctoral level and have the requirement for the total length of 'clinical training' reduced by 12 months: the Academic Stream.

doctor combined with the excitement of new discoveries through research and the reward of seeing those 'light-bulb' moments as you teach students. For me, there is still a real excitement in learning new things and then being able to pass this knowledge on to others. As clinicians we have the privilege to touch the lives of thousands of patients over a career, but as a teacher and researcher that can be multiplied a hundred times over.

How do I get started?

There is no single career path into academic medicine. I was fortunate enough to go to a medical school that included a six-month research project as part of the core curriculum and gave me my first taste for research, but it was not until I took three years out of my clinical training before starting work as a registrar to do my MD that knew I wanted to be an academic.

The College has recognised the need to nurture academic development through a range of initiatives including a more structured career pathway for academic Trainees that will allow them to undertake a research higher degree as part of the Integrated Training Program (ITP) (see Box 1). As a research project is now part of the ITP requirements this offers one potential starting point, but the key is really to sustain the interest and find someone to mentor you. If you have had previous research experience you may be able to build on that, but more often it's a question on seizing an opportunity presented to do a research degree. This will provide you with the training to develop a research project and, in turn, to supervise your own research students. The publications and presentations you do as part of this

will be invaluable in helping you get academic positions later and by the time you have finished your PhD you will probably know more about the subject you have been researching than anyone else in the world. The key challenge is to pick the right time to do this. Too early and you run the risk of losing academic momentum when you return to complete your clinical training, too late and the drop in income is more difficult to manage.

The next step is normally to apply for an academic position as a senior lecturer or lecturer. There are a relatively few of these, but the pool of applicants is even smaller in Australia and New Zealand. Indeed, one of the advantages of an academic career is that once you demonstrate an ability to produce results and attract funding universities will come looking for you.

Conclusions

After many years of bench-top focused research in health, the emphasis (and therefore funding) is now shifting to more 'translational' research, with a clearer need to link scientific endeavour to clinical outcomes. Clinical academics, with a foot in both the clinical and laboratory 'camps', will be at the forefront of this and are likely to be greater demand than ever. The increasing demand for leadership and high-quality medical education at both postgraduate and undergraduate levels presents similar opportunities for academics whose talents lie more in the scholarship of teaching and learning. With better support for academic training in O and G there are more reasons than ever to consider this path. Personally, I cannot imagine a career more varied, more stimulating and ultimately more rewarding.

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The future of GP obstetrics: have we done enough?



Dr Jeff Taylor
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DSM
Inaugural chair GPOAC
Coordinator of DRANZCOG
oral exam

The new Certificate of Women's Health and the revised curriculum for the Diploma and Advanced Diploma were introduced two years ago. Why were the new qualifications needed and what has happened since?

In 2007, RANZCOG commenced a much-needed review of the training and assessment requirements for the College's Diploma (DRANZCOG). Unlike the numbers entering midwifery, the number of doctors practising GP obstetrics was entering a level of unsustainability. The College was facing an exodus of retiring GPs who had practised obstetrics for decades

who were not being replaced by a new generation coming through the Diploma training programs. This, combined with the closure of over 200 maternity units and an increasing push by midwives for independent practice, resulted in a drop of GPs practising obstetrics from 2200 to 1815 over a ten-year period.¹

At the time, there were few incentives for medical students and doctors to take up GP obstetrics in future practice. Medical students were experiencing either minimal exposure to the labour ward in their undergraduate clinical training or increased resistance from midwifery staff to the students' presence in the labour ward. In addition, once doctors had entered a formalised GP training program, a return to hospital-based training resulted in the corresponding decrease in remuneration. These disincentives led to an overall drop in DRANZCOG trainee numbers.

Previously, doctors had the option to undertake either the DRANZCOG or the DRANZCOG Advanced. The DRANZCOG was tailored for GPs wishing to provide a high standard of routine antenatal care and perform low-risk vaginal deliveries. The DRANZCOG Advanced targeted GPs who would be providing women in rural and remote parts of Australia with access to a skilled clinician able to perform emergency caesarean sections. Other skills expected of doctors with the DRANZCOG Advanced at the time included the ability to perform an open appendectomy and laparoscopically manage ectopic pregnancies. The forced closure of many urban obstetric units meant DRANZCOG holders were not using the intrapartum component of their qualification, leading to the introduction of alternative programs that focused primarily on the delivery of office-based care.

Between 2007 and 2011, every aspect of the former Diploma training programs was reviewed and extensively debated in light of the healthcare needs of women in all areas of Australia. The Education and Assessment (EA) Subcommittee of the Conjoint Committee for the Diploma of Obstetrics and Gynaecology (CCDOG), a tripartite committee of RANZCOG, the Royal

Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM), was responsible for the review. The feedback sought from all DRANZCOG stakeholders – including, training supervisors, heads of hospital O and G departments, area health services, consumer groups and doctors who had most recently been awarded the Diploma – directly informed the review process. While many of the fundamentals of obstetric care have remained essentially the same for the past two decades, it was evident from the review that the training program could more effectively equip Australian GPs with the necessary skills required to provide the highest level of care to women, not only in the urban GP practice, but also in rural and remote communities. Furthermore, the program had to adapt to the increasing breadth of knowledge that was emerging from new research and utilise the latest methods and technologies to most effectively support GP obstetricians in training.

To address the varying healthcare needs of women in Australia and the corresponding skills necessary for GPs in order to deliver that care, a three-tiered structure of qualifications was developed based on a 'building-block' principle. The Certificate of Women's Health (CWH) and the revised DRANZCOG and DRANZCOG Advanced build upon each other in terms of both theoretical knowledge and clinical skills required, are facilitated by an extensive array of purpose-built online modules and are underpinned by a robust assessment regime.

The CWH is designed to be completed within the trainee's place of practice, be that a GP clinic or hospital, and use the expertise of RANZCOG Fellows and Diplomates with whom the trainee has regular contact and who can act as appropriate mentors. Supported by dedicated online resources, the trainee is able to remain within their practice and complete a logbook and the workplace-based assessments of a number of skills-based procedures, assessed by the trainee's mentor. A multiple-choice question written examination is also included in the suite of assessment tools. The inherent flexibility of the CWH program allows trainees two years to satisfactorily complete all the training and assessment requirements. The CWH is now widely considered appropriate for those doctors wishing to provide high-quality shared care.

The revised DRANZCOG builds on the knowledge and skills of the CWH, requiring trainees to undertake work in an obstetric unit so as to develop their low-risk intrapartum skills. The assessment regime for the DRANZCOG also consists of a number of workplace-based assessments of obstetric skills, as well as additional in-training requirements. The traditional multiple-choice question written and multi-station oral examinations remain in the revised program.

The revision of the DRANZCOG Advanced focused on its relevance

to rural and remote GP practice. Previously, DRANZCOG Advanced trainees were required to develop their skills in performing laparoscopy as well as open appendectomy. The review demonstrated that few DRANZCOG Advanced holders were performing these procedures in their daily practice and, thus, finding it difficult to maintain competency. It was considered, and rightly so, unnecessary for a candidate who would do very few laparoscopic procedures to be then competent in the laparoscopic management of an ectopic pregnancy or have the ability to perform an open appendectomy. The revised DRANZCOG Advanced places a greater emphasis on the ability of the rural GP practitioner to perform procedures that are effective in stabilising the unwell patient. Completion of supplementary training courses, such as the Anatomy of Complications Workshop and the Managing Obstetric Emergencies and Trauma (MOET) course, although not mandatory, is strongly encouraged. Furthermore, as ultrasound has become increasingly affordable and readily available, the revised DRANZCOG Advanced training program now also includes an ultrasound component, enabling trainees to develop skills in performing early and focused ultrasound, allowing women to remain within their communities for these procedures.

The revised women's health training programs for GPs have been in operation since August 2011, which begs the question – have the implemented changes led to a tangible difference in the number of doctors entering the training programs? Pleasingly, the answer is: yes. More than 100 trainees are currently undertaking the CWH, while DRANZCOG and DRANZCOG Advanced trainee figures have trebled. RANZCOG has gone from an organisation losing up to 150 Diploma holders each year to, now, having more than 2500 GP obstetricians practising with the DRANZCOG or DRANZCOG Advanced qualification. This is further encouraged by Practice Profile data demonstrating that more than 50 per cent of the GP obstetrician workforce is aged under 50 and over 90 per cent of respondents indicated their intention to continue with intrapartum care for the next five years.² I believe we should be proud of what RANZCOG has achieved.

When faced with a declining number of procedural GPs, RANZCOG had two choices: it could have either stood by, as other colleges have done, and watched the demise of GP anaesthetics and surgery, or do something about it. It chose the latter. We now have a flagship training program specifically tailored to the needs of GP practitioners; qualifications that offer flexibility and that are becoming the first choice for GPs wishing to provide the highest quality women's healthcare. With the revised program and the additional support provided for trainees, we now have a situation where the future workforce needs of our profession, as well as those who seek our care, are being secured.

References

- 1 Minutes of General Practice Obstetrics Advisory Committee (GPOAC) 2005.
- 2 Diplomates Practice Profile 2012. RANZCOG.

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Training GP proceduralists



Dr David Iser
FRACGP

Training as a GP proceduralist has become a hot topic for many recent medical graduates. What support is currently available?

While a surge in interest in the role of the GP proceduralist is extremely encouraging for those small towns trying desperately to provide obstetric and surgical services, it does raise a number of questions that need to be addressed.

There are two issues that are very important:

- Firstly, the reality that most GP obstetrics is carried out in small country towns means the throughput of such obstetric units is often small and raises the question: how do GP proceduralists gain adequate case numbers to maintain their skills?
- Secondly, how do these same GP proceduralists access leave for holidays and training opportunities given their absence may result in an unsustainable workload (including on-call load) for the remaining doctors?

Fortunately, these issues are addressed by funding opportunities under grants administered by RANZCOG, the Royal Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM).

The Rural Procedural Grants Program (RPGP) allows accredited GP obstetricians to claim ten training days at \$2000 per day (\$20 000/year) for approved training.

This funding is available for a variety of clinical activities, including conferences, courses, small group learning activities and clinical placements at larger obstetric units. These placements often provide an excellent source of obstetric numbers to maintain and even improve skills within a short period.

Furthermore, regional obstetricians are often very keen to be involved in such programs and see this as part of their mentor role, while providing extra workforce for their own health service. There are also hospitals throughout Australia that are considering this model as a means of staffing obstetric units in the long term.

Another program available for rural GP proceduralists is the Rural Obstetric and Anaesthetic Locum Scheme (ROALS). This program was formerly the Specialist Obstetric Locum Scheme (SOLS), but has now been combined with the GP Anaesthetics Locum Service and has hence been renamed. It is administered by RANZCOG and provides funding and support for obstetric or anaesthetic cover by approved practitioners.

The service is easily accessed and is also helpful in providing contact details of likely practitioners. This saves the practice time and cost, in terms of advertising and so forth, and provides funding to help with the cost of wages, travel and other expenses. Thus the

ROALS program goes a long way towards solving the second issue mentioned above, that is leaving one's practice with inadequate cover while attending to one's own educational activities.

It is also important to note that both programs are well supported. There has always been the possibility that programs of this kind would suffer from bureaucratic rules, creating barriers that hamper access. Fortunately, this has not been the case, with both programs being extremely user friendly. The staff administering these funds are exceptionally helpful, efficient in distributing funds and promote an atmosphere of assistance and encouragement for approved programs.

The General Practitioner Procedural Training Support Program (GPPTSP) is available to provide financial support for practising GPs to undertake training in anaesthetics (Advanced Rural Skills Training in Anaesthesia) or obstetrics (DRANZCOG Advanced). The scheme is funded by the Australian Federal Government and managed by ACRRM (anaesthetics component) and RANZCOG (obstetrics component); 15 places were offered in the 2013 intake (Round 4), which was open for applications from 1–31 July 2013.

GP registrars interested in undertaking procedural training should contact their regional training provider or state health department.

If the enthusiasm for training as a GP proceduralist among recent medical graduates results in increased numbers of skilled doctors then it will be very important for the medical colleges to ensure the viability of all support programs in terms of indexation for inflation and capacity to accommodate the increase in numbers looking to benefit from such grants. Let's hope the RPGP, GPPTSP and ROALS programs continue for the sake of the GPs providing long-term care to rural and remote patients.

Further information

For further information on the schemes mentioned in this article, please visit the following websites:

The Rural Procedural Grants Program: www.racgp.org.au/rural/traininggrants .

The Rural Obstetric and Anaesthetic Locum Scheme: www.roals.org.au .

The General Practitioner Procedural Training Support Program Obstetrics: www.ranzcog.edu.au/gpptsp.html .

The General Practitioner Procedural Training Support Program Anaesthetics: www.acrrm.org.au/gpptsp .

Rebirth of the rural generalist

Tony Urquhart
Australian College of Rural
and Remote Medicine

Comparing major metropolitan maternity hospitals with the maternity services in regional and remote Australia is to compare apples with oranges.

Rural general practitioner Dr Sandra Mendel works in a kind of 'tidal' zone where the rural and metropolitan frequently overlap. Her practice is Apple City Family Medicine in Orange, New South Wales, where she shares care of her maternity patients with the base hospital, which delivers just over 900 babies a year. Orange has two visiting medical officer obstetricians and a recently appointed staff specialist obstetrician.

Its maternity facilities include a 12-bed inpatient ward; a four-bed, level two newborn care unit, currently accepting babies from 34 weeks gestation; and four birthing suites.

Orange hospital is also a referral centre for smaller maternity units in neighbouring towns – such as Cowra, Parkes and Forbes – where general obstetric services are provided by local GP obstetricians.

Dr Mendel shares the care of mothers-to-be with the hospital obstetricians and midwives. She said her practice of seven GPs (including a GP registrar) has a very positive, collaborative working relationship with the hospital staff: 'The shared care works very well. And it is reassuring for our patients to feel that their care has continuity and cohesion.'

Dr Mendel said she was encouraged to pursue obstetrics by an inspiring mentor. She gained her DRANZCOG in 1997, and qualified in general practice a year later.

'I had a fantastic mentor who was a GP obstetrician and was

fortunate that the two obstetricians at the Orange hospital were both very encouraging and supportive,' Dr Mendel said.

'For me, obstetrics is one of the nicest parts of general practice. The birth of a child is the most wonderful moment for the parents and everyone in their extended network of family and friends. Most mothers have relatively trouble-free pregnancies and deliveries. But each birth is special because of the profound effect that a new life has on so many people.'

She said that when she arrived in the district, in 1996, there were very few full-time female doctors. Today, though, obstetrics seems to have a balance of female and male practitioners.

The mother of two splits her professional time between her GP practice and her role as Director of Education with the Australian College of Rural and Remote Medicine (ACRRM).

'The College is a strong advocate of rural generalism, obliging its aspiring Fellows to gain specialised training in disciplines such as obstetrics, anaesthetics, surgery and emergency medicine as a mandatory part of its general practice primary curriculum.

'Smaller communities that cannot support a resident obstetrician can sustain one or more rural generalists whose scope of practice includes obstetric qualifications,' Dr Mendel said. 'So specialist and generalist obstetricians each play an important role, and there is keen demand for each.'

Dr Mendel is an accredited GP supervisor of registrars and medical students on placement in her practice. She wrote her Masters of Medical Education thesis on external clinical teaching.

Obstetrics was one of the founding specialised training areas in the ACRRM Primary Curriculum. About 20 per cent of current Fellows of ACRRM have obstetrics and indications are that about the same percentage of registrars are choosing obstetrics as their advanced specialised training component.

The long-standing working relationship between RANZCOG and ACRRM continues through the Joint Consultative Committee on Obstetrics, and the full-day workshop that RANZCOG presents each year at ACRRM's annual conference (Rural Medicine Australia).

The two colleges also manage the General Practice Procedural Training Support Program on behalf of the Commonwealth Government. This program aims to improve women's health services in rural and remote regions by providing grants to GPs to gain advanced anaesthetics and obstetrics skills. RANZCOG manages the obstetrics grants while ACRRM manages the anaesthetics grants.

ACRRM has also developed the one-day Rural Emergency Obstetrics Training (REOT) workshop for rural doctors with little or no special training in obstetrics.



Dr Sandra Mendel finds the shared-care model works well for her patients in Orange, NSW.

DRANZCOG training in FNQ



Dr Alexa Bendall
FRANZCOG Trainee

In 2010–11, I was lucky enough to undertake training for the DRANZCOG Advanced at the Cairns Base Hospital. There are not enough positive adjectives in my vocabulary to describe this experience.

Cairns was the first place I was exposed to the reality of obstetrics and gynaecology; a specialty for which I have developed a great passion and which I now hope will be a large part of my life far into the future.

Cairns offers four places a year to potential Diplomates. The DRANZCOG Advanced takes 12 months to complete and equips doctors with skills in management of a birth suite, instrumental delivery, caesarean delivery and basic gynaecological procedures, such as dilatation and curettage. The DRANZCOG, that is the six-month option, is not offered. The reason for this preference for the DRANZCOG Advanced as opposed to the DRANZCOG qualification is that Cairns Base Hospital services an extensive area, from Cardwell to the Torres Strait and west to Weipa. Many of these communities are remote and transport of patients from them to Cairns can be both time consuming and expensive. It is therefore prudent to have several generalist doctors (including GPs and rural generalists), who are trained in O and G, placed in key communities throughout the region. Cairns Base Hospital is the obvious choice of facility in which to train these doctors.

The DRANZCOG Advanced trainees in Cairns Base Hospital, colloquially known as the obs and gynae principal house officers (PHOs), are responsible for the junior medical staffing of the birth suite on most shifts. While covering the birth suite, they are also on call for any woman with gynaecological emergencies who presents to the emergency department. Given the unique and diverse population that is served by Cairns Base Hospital, this means that PHOs are exposed to a wide range of clinical presentations, both gynaecological and obstetric.

As the PHOs are usually the first doctors with O and G expertise to see patients, the experience gained in managing emergencies is also substantial and invaluable. PHOs are rostered to elective caesarean lists; expected to conduct surgical management of miscarriage; and are asked to assist in more complicated procedures, such as laparoscopic salpingectomy for ectopic pregnancy. One of the aspects of DRANZCOG Advanced training in Cairns that I found the most valuable was the support from senior clinicians. The consultants were approachable and eager to teach.

As examples of the work done by GP obstetricians after completion of their DRANZCOG Advanced, there are currently at least three GP obstetricians on Thursday Island in the Torres Strait who owe their obstetric experience to Cairns Base Hospital. These doctors, along with a number who have trained elsewhere, including in South Africa, face the challenge of caring for the many women in the Torres Strait who become pregnant – a population in which obesity, gestational and pre-gestational diabetes, substance use, rheumatic heart disease, renal disease and domestic violence are more prevalent than in much of the rest of the country. They also treat and stabilise women suffering from evolving emergencies that are transferred from the southern reaches of Papua New Guinea.

One GP obstetrician related to me the story of needing to talk an Indigenous health worker on a remote island in the Torres Strait through a breech delivery on the telephone. The health worker had never so much as felt a cervix before, let alone conducted a complicated delivery. Tragically, the baby in that case died. However, there are many more stories in which the GP obstetricians on Thursday Island have saved the lives of both mother and baby.

Other centres where GP obstetricians are invaluable in the Far North Queensland (FNQ) area include Innisfail, Proserpine and Atherton. A number of graduates from the Cairns DRANZCOG Advanced program have gone on to work for the Royal Flying Doctor Service, where they provide much-needed women's health outreach clinics as well as managing transfers of pregnant women and patients with gynaecological conditions. One Diplomat has gone on to be an instructor for the Advanced Life Support in Obstetrics (ALSO) course.

Of course, there are those of us who started the DRANZCOG qualification simply hoping to gain a better understanding of O and G, to better equip ourselves for a career in general practice, but ended up falling in love with the discipline so much so that we will never leave.

Perhaps the one negative aspect of my time in the O and G department in Cairns was the long working hours. This was sometimes gruelling, but it did mean that Trainees were able to pack a great deal of clinical experience into a single year. For more on this topic, please refer to the article written by my colleague Dr Michelle Harris (see page 28).

Medical pamphlets

RANZCOG members who require medical pamphlets for patients can order them through:
Mi-tec Medical Publishing
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You can also download the order form from the RANZCOG website: www.ranzcog.edu.au.

Post-DRANZCOG pathway



Dr Louise Sterling
MBBS(Hons), FRACGP,
DRANZCOG Adv and DCH

In Gippsland, Victoria, we have created a post-DRANZCOG pathway to successfully facilitate the transition from hospital house medical officer to independent, competent and confident GP obstetrician.

Many DRANZCOG and DRANZCOG Advanced trainees feel ill-equipped to undertake independent intrapartum care at the completion of their training term. This represents a missed opportunity to realise the potential to create new GP

obstetricians (GPOs). This is unfortunate as GPOs have much to offer women at all stages of their pregnancy journey. Contributing factors may include the lack of a clear career pathway (more likely if trained in a unit where there are no practising GPOs), lack of confidence in their skills (real or perceived) and a perception that procedural medicine is no longer a part of modern general practice. The latter is often reinforced by colleagues and superiors who are now, more than ever, likely to be non-proceduralists.

In Gippsland, like most rural areas of Australia, the declining numbers of GPOs has threatened the viability of maternity services. If these units were to close, it would result in greater pressure on the larger regional units and their specialist obstetricians. In recognition of this, there has been an increasingly coordinated Gippsland-wide approach to the development of GPO training and continuing professional development (CPD) program. This has included expansion of DRANZCOG training at the larger (specialist-led) units, including a three-month rotation to Dandenong Hospital; post-DRANZCOG posts – Community Obstetric Bridging Posts (COBP) – at the same units in addition to the smaller (GPO-led) units; upskilling of existing GPOs to provide lower uterine segment caesarean section (LUSCS); regional GPO days; specialist support/mentoring to regional GPOs through an informal email Q&A forum; and specialist involvement in subregional education meetings. The program is continuing to evolve with new developments, such as rotations to Katherine in the Northern Territory and shared care credentialing.

These combined efforts have resulted in a resurrection of GP obstetrics as an exciting and vibrant subsection of general practice

in Gippsland. There is a sense that GPOs belong to a special club of proceduralists. Registrars are now competing for training positions, leading to a higher calibre of trainees. One GP registrar who wasn't participating in intrapartum care, despite having completed her DRANZCOG in Melbourne, commented she felt that she was missing out compared to her participating colleagues. She is now planning to undertake DRANZCOG Advanced training.

One of the key elements to the success of the regional GPO training has been the post-DRANZCOG pathway, referred to locally as COBPs. The COBPs are the result of a partnership between Southern General Practice Training (SGPT), the local provider of GP training, general practices, hospitals and the Victorian Department of Health. They involve 12 months of full-time training consisting of a general practice training term and a community-based obstetric term run concurrently over the year. The trainee is based in a general practice clinic where, ideally, there are established GPOs and procedural medicine is encouraged.

The COBP can contribute to the fourth year of training (advanced special skills) in both the Royal Australian College of General Practitioners (RACGP) and Australian College of Rural and Remote Medicine (ACRRM) training pathways.

The COBP follows on from the hospital-based DRANZCOG training term so, from day one within the GP clinic environment, trainees are developing their identity as a procedural GP. Specific activities of the post depend on the requirements of the trainee, but common components include:

- participation in antenatal clinics, working alongside a specialist or GPOs;
- facilitation of a significant intrapartum workload, in other words first on call for labour ward, with a senior doctor available as back up;
- supernumerary attendance at elective LUSCS lists (often at larger regional or metropolitan hospitals);
- attendance at RANZCOG Provincial Fellows Meetings and the Annual Scientific Meeting;
- completion of any recommended courses not achieved during training term, for example, the Vacca Research Vacuum-

Case study

'There is a steep learning curve going from resident-type obstetrics to GPO and the bridging post allowed that transition to happen in a more secure or protected setting. I gained a lot of advice from my GPO colleagues and the consultant obstetricians to help make myself a framework for my scope of practice, my comfort zone and my boundaries as to what I am comfortable with and what needs referral. I got the sense that I was a valued member of the team in our local maternity services and, as such, my colleagues had an interest in making sure I didn't get burned too early in the game. It was good to be able to see a blend of antenates both in general practice and the shared-care women in the hospital antenatal clinic and, of course, the rostered night first on call for the week ensured I still had a lot of supported labour ward experience while I built up my case load in my first few months as a basic term GP registrar. The most satisfying part of the bridging post was the continuity of care with women and their families from pre-conception counselling through to the postpartum period and, excitingly, the subsequent pregnancies.'

- assisted Delivery Workshop, and intermediate ultrasound; and the consolidation of a network of experienced colleagues for support and mentoring.

Throughout the COBP, supervision is commensurate with the trainee's abilities and inevitably it is reduced over the course of the year as the trainee's confidence and competence builds. For example, supervisors may attend initially for all mid-cavity instrumental deliveries, then may be onsite, then informed and, finally, simply be available should the trainee request advice or assistance.

In our situation funding is supernumerary, allowing the trainee to be paid via a salary and the supervisor according to their usual remuneration. Around the country different funding options are potentially available.

So far, the results have been very positive. Of 12 doctors who have undertaken a COBP, ten continue to practice intrapartum care. The

other two doctors provide significant antenatal and postnatal care to women in their communities (one metropolitan). Owing to the success of the program, we have nearly saturated the capacity of the Gippsland maternity services to accommodate new doctors. This is a very nice 'problem' to have.

Other key elements to the success of our regional program have been the good will and vision of key clinicians such as Dr David Simon, staff specialist at the West Gippsland Healthcare Group, and Dr James Brown, director of training at SGPT. They are currently undertaking a formal evaluation of the program in partnership with Monash University.

Conclusion

A structured post-DRANZCOG pathway has proven to be an effective method to transform DRANZCOG holders into valuable independent competent and confident GPOs in Gippsland, contributing to a vibrant and flourishing obstetric workforce.

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Motherhood and medicine

Dr Alex Mowat
FRANZCOG Trainee

Along with becoming a parent, O and G training has taught me more about my capabilities and, possibly more importantly, my limitations than anything else I have done in life.

In 2008, I started O and G training with a 15-month-old son, Oliver, and a three-month-old daughter, Charlotte Poppy. In August of this year, I will complete my fifth year of training and welcome our fifth child into our family. We are all looking forward to the arrival of 'Ziggy'. Next year, I will start my three-year urogynaecology subspecialisation. So for me, as for many other Trainees, the demands of O and G training have always competed with being a mother.

There have been ups and downs, triumphs and disasters, but when all is said and done, training to be a specialist O and G has been, and continues to be, an awesome journey of self and professional discovery. It is really only now, as I am nearing the end of my general training, that I can acknowledge that it has delivered everything it promised to me all those years ago as a resident.

Firstly the highlights, they have been abundant: becoming competent at running a busy labour ward, especially alone at

night; learning to perform vaginal and laparoscopic surgery; and developing the ability to use ultrasound to measure a femur and, more recently, even cervical length. It still thrills me to think back to when I couldn't do any of these things. I remember vividly that feeling of longing to be that senior registrar delivering a baby with forceps or performing a vaginal hysterectomy. For all of these things, I am grateful for the training I have received. The other equally important highlight has been the friends made along the way. The often stressful and frustrating work and training environment has lent itself to nurturing friendships that have carried me through the rough patches and provided wonderful companionship through the good times. As I have become more senior in the ranks of registrars, I have also found it humbling and rewarding to have the opportunity to provide support and encouragement to junior registrars who are often struggling to get over similar hurdles to the ones I encountered and eventually overcame thanks to the mentorship I similarly received from my senior registrars.



The author and her family.

Another highlight of the program was my year in Cairns, as a third/fourth-year registrar, which was also the year we had our fourth child. I cannot express the depth of my gratitude for the support and understanding I received from the entire O and G department at Cairns Base Hospital. It changed my concept of what is possible and achievable with the right attitude. I took six weeks of leave and then returned to work with a commitment to continue breastfeeding as I had with my other children. I was granted the use of the consultant flat across the road from the hospital so that I could employ a nanny to sleep there with my baby while I was working night duties and bring her over to me for feeds. Never once was I made to feel like I was causing an inconvenience when I fed my daughter at work, often having to briefly pause operating lists. I was also able to take her up to Thursday Island with me for a week of outreach (where I employed a local woman to care for her while I was working). During these busy months I was also preparing for my oral exam. It was a juggling act only made possible through the progressive attitude of the director, Paul Howat, as well as the acceptance and moral support I received from all the other consultants, the registrars and midwives. This experience revealed it is possible to have a flexible yet functional workplace that supports Trainees not only in their training, but also in their lives.

The other essential player during this time, as always, was my husband who took leave from his final year of anaesthetic training for four months to look after our new baby while I returned to work. Our partnership and our shared goal of completing our specialisations while nurturing our young family is the foundation of our daily lives. Without this commitment to the other's dreams, they would remain just that.

However, some experiences during my training have seemed to demonstrate that our profession itself could benefit from a little nurturing. There are two particular areas on which I'd like to reflect. The first involves the support structures in place for Trainees wishing to take time out of their training to have or care for children. It is often a difficult decision trying to weigh up the costs of adding time to the training program, diluting clinical experience and reluctance to inconvenience employers against the personal costs of delaying parenthood. My advice to junior Trainees wanting to plan a family is to avoid placing too high a priority on the calculated impact it will have on their training. It is hard to judge the best time from a training point of view to have children and, of course, sometimes even harder to fall pregnant at the planned time. I have found it is possible to fit O and G training around having a family and, although it hasn't always been easy, I would do it again if I had my time over. However, a better support structure would make the juggle easier, particularly with regard to planning the return to, and completion of, training after maternity leave. One of my most difficult experiences was trying to negotiate where I would complete my ITP training after having taken six-months of maternity leave during my third year of training. It may be time to invest in a designated College employee whose responsibilities include the re-planning of the training timeline for those taking leave. Each Trainee is different in the length of time they want to stay at home with their baby and the way in which they wish to re-enter training (full time or part time). It makes sense to have an easy way of swapping placements around for registrars taking leave and pairing up registrars who wish to work part time. Having a designated person to help plan training around having children would allow Trainees applying for accredited posts to be open and honest about not only being pregnant, but also planning to become pregnant. At present the majority (80 per cent) of

Trainees starting out in O and G are female, so it is reasonable to predict that these issues surrounding maternity leave will become increasingly significant and that we should recognise and prepare for this as part of the natural history of the specialisation.

The second area of concern is my personal hobby horse, the issue of surgical training. When we are granted our FRANZCOG we are recognised as surgeons, so it is demoralising that many new Fellows cannot skilfully operate. In the present, a generalist, in other words a specialist in both O and G, which is what most of us would expect to be 'spat out' as at the end of a six-year training program, needs to be both skilled at caring for and delivering pregnant women and also needs to be a surgeon, confident about performing vaginal, laparoscopic and some open procedures. The laparoscopic approach is now, more often than not, the only acceptable one to patients, whether they are undergoing a tubal ligation, an oophorectomy or a hysterectomy. I do not think it is unreasonable for Trainees to expect to be well trained in all of these surgical techniques. In fact, it should be tremendously disappointing when this expectation is not met.

'As a specialty, we need to be committed to our Trainees and dedicated to ensuring that they reach their full potential.'

I would like to see the surgical half of our training significantly augmented over the coming years. A purely apprenticeship-style model for surgical training is simply inadequate. I believe, as surgeons, we suffer from a lack of basic anatomical and skills training. While sufficient hands-on experience in the operating theatre is clearly hard to secure for a lot of Trainees, this is only one aspect of the deficiency. I passed both my membership exams without having to answer a single question on anatomy. I think we need to introduce a formal anatomy component and develop more stringent surgical skills requirements. One suggestion would be to introduce compulsory six-monthly surgical workshops in skills laboratories.

My expectation of a worthwhile training program is one that takes a talented and interested doctor and nurtures them until they become an excellent specialist. As a specialty, we need to be committed to our Trainees and dedicated to ensuring that they reach their full potential. While it is true that much of the responsibility lies with the Trainee, this doesn't relieve those charged with training registrars from the duties of nurturing and teaching. What underlies the ability to nurture is the desire to see an end product of which one can be proud. Another suggestion is formal College recognition of specialists who excel in their roles as teachers and mentors. Surgical training cannot, and should not, be left purely up to hospitals.

To end, I would like to acknowledge the enormous joy and fulfilment that my training has brought me so far and pledge to contribute to the fullest of my abilities towards our awesome specialty throughout my career. It is a privilege and a great responsibility to care for women and their families. Our training needs to be of the highest quality so we can all deliver care of the utmost quality to these women who trust us to look after them at their most vulnerable times.

Walking in their shoes

Dr Anne Coffey
FRANZCOG

What happens when O and G professionals experience reproductive loss?

Dr Brad Robinson
FRANZCOG

Reproductive loss is a significant life event for many individuals, couples and families. It creates a crisis of grief that can disrupt work and family functioning over months and sometimes years. Reproductive loss encompasses a range of losses including miscarriage, stillbirth, termination of pregnancy, neonatal death and involuntary childlessness.

The implications of reproductive loss in professionals involved in maternity care have not been addressed in the scientific literature.

In the general population, responses to reproductive loss vary, but some themes are consistent. Women experiencing miscarriage can experience intense grief and significant anxiety symptoms that can persist for up to six months after the miscarriage.¹ The lifetime prevalence rate of post-traumatic stress disorder (PTSD) in women who have experienced stillbirth is 29 per cent and the rate of PTSD in the third trimester of pregnancy subsequent to stillbirth is 21 per

cent.² Fathers also experience significant levels of anxiety and PTSD following stillbirth, which can persist in a subsequent pregnancy.³

Grief is an inevitable human experience. It is a natural response to loss and the emotions experienced extend beyond sadness to include anger, anxiety and despair. Grief is not an orderly or predictable process and this is particularly true in the setting of reproductive loss.

Complicated grief refers to significant and prolonged functional impairment after loss. Consequences may include depression, drug and alcohol abuse, and family breakdown. The risk factors for complicated grief after reproductive loss include the absence of surviving children, poor social supports and pre-existing relationship difficulties.⁴ Many people who experience infertility and reproductive loss will for some time avoid events that may increase distress such as visiting family or friends with babies or returning to the hospital

After the cyclone

In early 2011, I experienced the loss of my first pregnancy at 17 weeks gestation. I will never forget leaving the hospital that night with my husband, loading flowers into the car in the darkness of an empty car park. My baby was no longer with me, and my hopes and vision of the year ahead of me were shattered.

At the time, I was a senior O and G registrar. I informed my director that I would return to work in two weeks. I made the judgement that this would be the 'right' amount of time off. Despite my professional experience in caring for women during pregnancy loss, I had no understanding of the profound – and at times paralysing – grief that I would experience over the coming months. In those early days after the loss, I had not yet comprehended the almost impossible task that lay ahead of me: finding a way to work in a job where I was constantly confronted by pregnancy while grieving for the loss of my own.

Cyclone Yasi came to town two weeks later. I almost welcomed the distraction it brought in those early painful weeks. I returned to work after three weeks. The unit director was understanding and my role flexible, allowing me to not work on the birth suite until I felt ready. I faced unexpected and distressing scenarios frequently despite these changes. On more than one occasion I saw women with the same due date as my pregnancy in the antenatal clinic. One day I diagnosed a miscarriage at 17 weeks gestation in an antenatal clinic. For many months after this I would hold my breath while listening with the Doppler. I knew too much about what would follow if no heartbeat was heard. Negotiating these painful encounters and continuing to undertake routine work left me constantly, and at times overwhelmingly, exhausted.

Senior colleagues were patient and caring. Some staff, however, seemed to struggle to accept the length of time it took for me to return to usual practice. I witnessed the discomfort and difficulty that many midwives and obstetricians experience in talking about grief and reproductive loss. This discomfort tended to create unhelpful and misguided comments such as: 'this will be a really good experience for your career' and 'well, at least you know all about this'. Despite the challenges, continuing to work provided me with intellectual stimulation and a sense of purpose. The pregnancy loss had created a profound sense of personal failure and continuing to care for women provided an antidote to these feelings.

Work became a little easier after the passing of the expected due date of our baby. However, a second pregnancy followed soon after. This pregnancy was dogged by complications and was a dark and difficult experience. I was constantly preoccupied with the possibility of loss while continuing to grieve. I worried that I would not have the strength to recover or return to my chosen profession if I lost another baby. However, 16 months after that terrible day, my husband and I were able to experience the joy of leaving hospital with our second daughter. In contrast to our previous experience, it was a sunny day and the car park bustling as we loaded up flowers, bags and our baby.

It took two years before I could practise obstetrics comfortably again. I remain grateful for the patience and support of senior colleagues during this time.

Anne

where care took place. Recovery is marked by a gradual return to, and increasing comfort with, these activities.

It is possible that O and G professionals who experience reproductive loss are at increased risk of complicated grief as they are unable to control avoidance of, and exposure to, emotionally distressing events during their work. Taking a long period of absence from work or modifying work arrangements may not be feasible for some practitioners. These issues require further investigation.

O and G professionals face other challenges in this setting. They may require medical treatment within the service in which they work, in particular, in rural and regional settings. This may create additional distress when returning to work in the setting of pregnancy loss as they may not be able to avoid painful places such as the room in which their baby was born. Their care will have been provided by peers and sometimes colleagues with whom they work. Doctors as patients often experience compromises to their privacy during care and this risk is even greater when treatment is provided within the profession. These professionals may also be subject to the misconception that their training provides them with expertise in the personal journey of grief after reproductive loss. This is a dangerous assumption, which may lead to inadequate empathy and support in the workplace, despite the challenges faced by the bereaved as outlined above.

O and G professionals who experience reproductive loss require empathic support from colleagues over the months and years that follow. Where possible, colleagues should seek to provide flexibility in work arrangements, particularly in the first six months to one year of bereavement. Some professionals may choose to make permanent changes to their scope of practice after reproductive loss and this decision should be supported. The unique and very challenging aspects of the grief process for O and G professionals should be acknowledged. Colleagues should remain aware of events that may lead to increased distress or return of grief such as anniversaries, an expected due date, if relevant, or a subsequent pregnancy. If complicated grief is evident then professional psychological support may be required.

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Things my Gigi has taught me

I'm writing this from a hospital room with one eye on the Ashes Test and the other on my two-day-old son, Quincy, who is snuffling peacefully next to me in his cot. My wife, Bec, and I are deep into that newborn fog as we marvel at what we've created while navigating the sleepless nights and the early challenges of remembering how exactly to bath such a tiny baby.

However, three years ago this very scenario seemed a million years away. Then, we were deep in the fog of grief having lost our daughter Georgie to stillbirth at over 36 weeks – ten days before her planned delivery. Back then the idea that we'd have the courage to endure the white-knuckle ride of another pregnancy seemed impossible.

Our pregnancy with Georgie – or Gigi as we'd come to know her – was the very textbook definition of uncomplicated. Despite the seemingly constant examples of heartbreak and tragedy obstetricians are exposed to, we'd merrily sailed through oblivious to even the potential for calamity. One Saturday morning, as I was leaving to start my weekend registrar's shift on a busy regional hospital labour ward, I passed Bec, rubbed her belly and told her to take care of my precious cargo. Later that same day I discovered Gigi was gone. Bec and I had joined a club no one wants to be a member of.

This encounter with grief of such magnitude was my first. Having never dealt with loss previously, I was blissfully unaware of what an unwelcome visitor it would be. Did I say unwelcome? It was raw, and searing and unrelenting. It physically reached inside me and changed me in such a way that I was terrified it would leave me forever broken; not to mention no longer able to do the job that I had changed careers five times to find, and one with which I was experiencing a passionate love affair.

Now, nearly three years later and with greater clarity, I can see that while this has diminished me, Gigi has given me gifts I am blessed to have received. Talking about her gives her meaning and purpose. Existence. Sharing this experience – in some way – brings her to life and gives her back to me. She has taught me that when people join this godforsaken club, they want to hear their child's name. They want you to ask for it and to use it.

By the same token, banish immediately from your clinical lexicon the expressions 'it was meant to be', 'at least you have other children', 'at least you can have more children' and, my personal favourite, 'it'll get better with time'. These platitudes not only don't help, but – worse – they are really a way for the treating staff to make themselves feel better. This is not about you.

Gigi also taught me that it's crucial anyone working in this field is aware of the services available to parents who are faced with the loss of their child. For example, when we lost Georgie nobody knew about Heartfelt, a national organisation of volunteer photographers who visit the hospital and take beautiful baby photographs. One of our greatest regrets is that we have only three grainy photos of our daughter.

Finally, if you ever care for such a parent in a subsequent pregnancy, you need to understand the sheer terror of the journey they are taking. You need to appreciate what an honour it is for you to shepherd them through, and offer them every reassurance and comfort you can.

Brad

Women in medicine



Dr Susan Evans
FRANZCOG, FFPMANZCA

A personal reflection on combining family, medicine and a satisfying professional career.

My mother wanted to be a doctor from her early years. When her father (the school headmaster) refused to let her study physics because he didn't consider it appropriate for a girl, she took to her bed for a week and refused to get up until he gave in. She won that one, but

lost later when, having been accepted into medicine, he refused to allow her to start the course. With no other means of financial support it was a decision she had to accept. She studied science and married my father (an intern) still with hopes of studying medicine, but the unreliability of spermicidal foam meant that a month later she was pregnant with me. Thoughts of ever being able to do medicine faded into the reality of Australia in the 1960s.

I, who knew from an early age that I would have my parents' support in whatever endeavour I chose, was more ambivalent. I accepted the position offered after casually filling out an application form (no UMAT or GAMSAT in those days) and 'not having anything better to do'. It is a decision I have never regretted. Medicine has been good to me.

Reliable contraception no longer a concern, my challenges have been those of so many women my age: how to combine career, husband, family and a need for personal challenge, in a generation where it was okay for women to 'have it all' as long as they 'did it all', and proved themselves doubly worthy of any opportunities given?

We were benefiting from a generation of women who, while not achieving their own plans, valued their daughters' education and ambitions. However, with few female mentors and even fewer who had combined work and family successfully, it did feel as if we were making it up as we went along.

As a new graduate, unspoken positive discrimination in favour of men in hospital environments was common, but generally not intrusive, and far less than I saw in other professions such as law. As young women, we noticed the increased interest in the career path of our male colleagues and it matched our experience socially. Among professional couples, 'his' career was generally considered more important and deserving of support, while 'hers' was considered more an 'optional pastime'. Not at all how we as young women graduates viewed ourselves, but just the way it was.

Life as a registrar

The selection for registrar positions was more random than it is now and heavily reliant on the professors' preference. My interview in Hobart (after sitting my 'First Part') finished with the suggestion that 'wouldn't I just prefer a GP position?' and a pinched bottom on the way out. Life was different then. It was with great pleasure that I accepted an offer in Adelaide.

My first year as a registrar started well, but became one of disillusionment. The consultants generally looked unhappy in their chosen profession, and I took 12 months off to reconsider my options. I returned a year later knowing that gynaecology was for me and I would drop obstetrics at my first opportunity.

As consultants, I think we sometimes forget how important our role as mentor is. Registrars value seeing someone in a role they can see themselves in. For me, my first list with Ossie Petrucco proved a turning point. The laparoscopy was inspiring and when I told him 'I want to do what you do', his initial surprise was followed by gracious and substantial teaching over many years, in what were the early days of operative laparoscopy.

'...from a professional perspective, the three years as a half-time registrar were the making of my career.'

When you realise life is different for women

Before children, being female in medicine is a small inconvenience. As professional women find everywhere, it is easy to work around gender issues while childless and imagine they don't exist. Maybe this is why the change when you become pregnant feels so stark? The desire to work, learn and accomplish isn't lost with delivery of the baby, but the ability to be 100 per cent available for the job is. Of course men aren't 100 per cent available either. Who would want to be? But life changes more for women – and it's harder to hide. As always, it is the colleagues that supported you when you were pregnant or vulnerable, who are forever remembered fondly.

In the early 1990s, even with all exams completed, a half-time training position wasn't something you could take for granted. It is a credit to our College that half-time training was accepted in principle around that time – even if negotiating this in practice wasn't easy.

Despite the difficulties, from a professional perspective, the three years as a half-time registrar were the making of my career. I loved my job even more when it was three days a week, arrived keen to work every day and truly believe that the hospital did well out of the arrangement. It also provided time for me to learn the skills I needed rather than those that suited the hospital rotation. Assisting private laparoscopic cases and attending workshops and meetings to improve my surgery were opportunities the full-time registrars busy on labour ward didn't have.

On completing my Fellowship after nine years on the labour ward despite no intention of continuing obstetrics, I just wanted to operate. My aim was to be the best laparoscopic surgeon I could be, and to care for my patients to the best of my abilities.

With no offers to join a practice, two children, a working husband to consider and no public hospital employment flexibility, I set up in solo gynaecology practice. Looking back, it was a blessing in disguise, as it forced me to learn how to find rooms, run a practice efficiently, employ staff, type quickly and set up computers when I had few patients and spare time. The reality of setting up a business as a woman back then seems laughable now, but I remember being turned down for a \$20 000 bank loan in the weeks after finishing my Fellowship because he considered me 'unemployed'. There were other banks.

Keeping relevant

Many of us will work as a specialist for 30 years. So, if the adage 'ten years is enough in any job' is true, how do we maintain enthusiasm when the excitement of another laparoscopic hysterectomy or vaginal breech delivery fades?

For me, the desire to continue learning and positively contribute in an area of need has led to the care of women with pelvic pain. During my training, like everyone, I dreaded seeing patients with chronic pain because I felt so powerless to help them. It was the days of rapid improvement in laparoscopic surgical technique and we had the (quaint) belief that if we could just do our surgery that bit better then we could cure pain.

It was when I had my own patients and saw them over time that I started to recognise the flaws in this. Even with beautiful surgery only some got better. Many others continued to have pain or had pain that recurred within a few months. Laparoscopy certainly had a place, but the concept that we could treat chronic pain with surgery alone was outmoded at best or deeply depressing if you took the patient's point of view. Nine years of training had not equipped me to manage pain.

Recognising that it was time for me to change, learn new skills and think more broadly has been a wonderful opportunity to remain relevant and interested.

I have been fortunate that these thoughts came at a time of dramatic change in the area of pain management, when the knowledge required to do a better job was readily available when I looked for it, and during the establishment of the Faculty of Pain Medicine with its supportive, multidisciplinary approach.

These days, seeing women and girls with chronic pain, individualising their care with or without surgery and working with other health professionals to optimise outcome is something I find truly satisfying.

What would I change about training?

It's a long haul. Current Trainees may already have completed an undergraduate degree before starting medicine, fulfilled bonded country placement requirements, spent time in service positions and completed years of research to enhance their chances of acceptance. They then work part-time as a registrar because the need to start childbearing has become imperative. Fellowship itself might be followed by yet further subspecialist study to finally arrive at the career they may have chosen 20 years earlier!

I believe that our specialty has enlarged beyond the expertise that one individual can maintain over a professional career, particularly with the ever-increasing requirements for accreditation and continued education. As such, it is likely that many Fellows will choose to narrow their practice to specific areas of our discipline.

Initiatives that allow Trainees to focus on their chosen area of practice and the skills they will require relatively early in training are welcome. When considering where my own practice has led, an opportunity to acquire broader 'pelvic surgeon' skills – and increased knowledge of gastroenterology, urology, musculoskeletal medicine and pain management during my training would have been advantageous.

For women entering our profession

Our daughter is a medical student with her choice of career no longer anything unusual. When you take on a challenging life, a good work-life balance is always difficult – but this is true for men as well as women.

I believe that women have already changed, and will continue to change, medicine. Possibly by being prepared to take on areas, like pain, that have been relatively neglected in the past – or by providing an alternative viewpoint on common conditions.

So what have I learned that could possibly be of use to a Trainee in 2013?

- Choose an area of specialisation. Combining work, family and ensuring that your work remains at a high standard is easier if you narrow your focus. My decision to stop studying obstetrics once my exams were completed allowed me to concentrate on gynaecology and, particularly, laparoscopic surgery.
- Choose an area likely to change over time. Health economics may mean that our duties are increasingly taken over by other health professionals. Problem-solving abilities are always valued – and change keeps you interested and relevant.
- Take the initiative to learn new skills. Fellowship training can't be expected to provide all the skills you'll need in practice. Private consultants see a different range of conditions and will often welcome your request to observe at their rooms or assist in theatre. Consider attending subspecialist meetings in your area of interest.
- Learn from men. Some skills seem to come more naturally to men. I have always admired the ability to fully focus on a single task and the ability to move on from setbacks without looking back. These skills can be learned.
- Choose your partner carefully. Behind most successful women is a partner who values her intellect and ambition.
- You don't need to do it all. As another gynaecologist told me: 'Once you have children expect to spend half your income on keeping home running smoothly.' Not just childcare, but optimally someone who will manage the everyday tasks and allow you unhurried time with your partner and children.

Where is my mother now?

After ten years at home raising children, my mother taught biochemistry to medical students, worked as a child welfare officer, helped found Tasmania's Domestic Violence Action Group and worked as National Secretary of the Australian Society of Friends, coordinating their International Development Aid Program in South-East Asia. In 1996, she was appointed a Member of the Order of Australia. In good health at 77, she still works – this time as business manager of a second-hand charity outlet, coordinating 70 volunteers efficiently and profitably.

She would have made a fine doctor, but her life has been full, challenging and positive. There are other paths than medicine.

The gentle art of lobbying

Dr David Molloy
FRANZCOG

There are many reasons to lobby government. The process is about maximising the benefit and preventing, minimising or reversing the harm of government's decisions.

Governments regulate, set standards and distribute money. When they perform these functions the outcomes can be helpful or harmful. This is where the lobbyist comes in. The endpoint of most of lobbying usually has some commercial impact on the area you represent.

It used to be so easy. The first time I negotiated a new item number for the Medicare Benefits Scheme (MBS) we wrote an eight-page submission and presented to the Department of Health. A relatively short meeting mediated by the Australian Medical Association (AMA), lunch with the Medical Advisor where we promised it was a really good procedure, some gentle argy bargy with the Department about the price and, finally, a relatively smooth passage of the new descriptor through the Minister's Office and, lo and behold, come November, there was a new item in the Gynaecology Schedule.

Now the art of medical politicking has become so much more complex. We are currently helping the gynaecological oncologists revamp all of their item numbers in the MBS, many of which are woefully underfunded. Our initial submission will run to over 250 pages. At that point, the process will have taken nearly two years.

In my very junior years, I listened to our senior representatives reporting on meetings that they had with government, particularly about the poor levels of remuneration for O and G. I was stunned by the lack of organisation, structure and purpose. There were no data. No one was really even sure how many deliveries were performed in Australia. Not only did we not go forwards, but we also went backwards when the global obstetric fee was introduced, which sliced remuneration for patients by about a third.

If we were to get anywhere as a speciality, we needed to become much more professional. The National Association of Specialist Obstetricians and Gynaecologists (NASOG) was established, in 1988, to provide the political structure and lobbying that could not be done within the College charter. Part of NASOG's eventual strength and success came from the fact that it worked in tandem with a high-quality standards body (our College).

This demonstrates the most important principle of medical lobbying. Represent the interests of patients and highest quality medical standards for the community and just rewards may follow. Good medicine and best practice don't come cheaply. Over the next 20 years our lobbying for change in the structure of private sector O and G and its remuneration became much more professional and successful.

How does one successfully influence government?

First, you need an organisation with a secretarial structure, funding and the ability to interact with other medical organisations. If you are to have influence you need a hat.

A title is essential for networking. Networking is one of the keys to successful lobbying. The AMA is our most important umbrella

medical organisation. It has a full-time secretarial and bureaucratic presence in Canberra. The AMA talks to the Department of Health and many politicians daily. Used properly, the AMA is an important key to Canberra. However, it is also vital to have a working relationship with your College, the GP organisations and any other specialities that overlap into your area. If you are trying to guide a reform through Canberra you don't want to see it fail at the last minute, blocked by another medical organisation for a lack of consultation or perceived disadvantage.

The government in Canberra has two wings: the first is the political arm of the minister, their office and the actual government itself; the second is the professional and full-time public servants of the department. The two arms sometimes work together. If you want to understand this relationship, watch *Yes Minister* several times.

If you introduce a submission or policy change then you choose either the political or the bureaucratic arm as your entry point. However, it is important to immediately take care of both arms. If you intend to take an idea in through the Minister of Health's office you must brief the public servants immediately. Similarly, if you are trying to work up an idea with a public servant, it is very wise to get the Minister's office on side at the start as well.

It is much better to go to Canberra with a deal in mind, rather than simply begging for money. When Parliament is in session there are queues of lobbyists and representatives lining up at Parliament House, just like the agents did with their patrons in ancient Rome. Nearly all of the lobbyists want money delivered in one form or another. It is, therefore, much better to go with a plan that delivers political wins and bureaucratic solutions in return for what you want. It is vitally important to be well researched and prepared. We now have access to much of the Government's data. However, extensive other research is important.

When we were lobbying for better obstetric remuneration, the key was to demonstrate that patients (voters) were increasingly disadvantaged by high gaps. There were no data to support this, so NASOG employed a nurse to act as a prospective patient and ring 600 obstetrician's offices and to obtain quotes. We gathered data on fees and patterns of billing that was the only verifiable data in Australia on the true level of obstetric gaps. We provided these data to the Minister, the Department and the press. The case for change was therefore based on fairness and equity in the Medicare system for disadvantaged consumers.

If one is to negotiate and lobby successfully it is like any other skill. While some people may have better natural skills, the best results are derived from appropriate training. I had the privilege of working with two of the best O and G lobbyists in the business: Dr Andrew Pesce and Dr Scott Giltrap. We went to many professional development courses in lobbying, negotiation, policy development and media management. These are invaluable training and are not to be underestimated. Too often doctors,

when outside their medical comfort zone, are rather like the patricians of Rome who simply assumed that because of their educative and social status that the right moves would slip into their brains as the enemy appeared over the hill.

Another key to success is a tight, well-researched submission. If the Department of Health is going to steer your proposal through the Minister's office and the other departments, especially Finance, the proposal must be watertight, well costed and well negotiated. This proposal must be backed up by making sure the Minister and their office understand the content and import of what you are doing. One page of dot points is usually sufficient for this.

At a political level, successful lobby groups meet their Minister as frequently as possible. Fundraising functions and dinners are important contact points. It is often useful, if you are in a position of influence in your institution or hospital, to have the Minister along to open something important, such as a conference. Activities that give the Minister a positive profile in their portfolios are helpful. We do use paid and professional lobbyists to help our cause as well.

It is important to work with Canberra in a congenial and professional way. Some have a very negative view of the Canberra public servants. However, my experience of Canberra has been, in general, a very positive one. It's fair to say that the public service does have a different set of processes to achieve a result than we use in the ward or the operating theatre. However, most public

servants that I have worked with understand the primary focus of their job is to administer the country in a beneficial way. If they are going to do that efficiently and effectively they need advice and assistance from professionals in their area. For medicine, that is frequently doctors. It is important in your dealings with the Department to be absolutely honest and accurate. Policy and legislative change have to jump a dozen hurdles and your professional integrity is vital.

A key quality to have is that of patience. Canberra rarely moves with the speed of the startled gazelle. Sometimes there is a happy coincidence where bureaucratic efficiency melds with political need, especially before an election, which can make the wheels spin amazingly quickly. It is extremely important to be alert for these opportunities.

Finally, if you are steering a major change, such as a revision of a significant section of the Medicare schedule, never relax. The last ten per cent of the process is 90 per cent of the effort. You need to be vigilant; constantly on the phone and e-mail to make sure everything is moving forward and no sudden unexpected glitches arise either from friend or foe.

How do you become a successful medico-political lobbyist? Get interested and join NASOG, the AMA and the College committees. Learn from your peers. Do the courses. Oh and, by the way, watch *Yes Minister* and *Front Line* regularly and then *Shogun* and *The Godfather*.



C-QuIP
Colposcopy Quality
Improvement Program

Web Portal

The Colposcopy Quality Improvement Program (C-QuIP) has been working with Solutions Plus, developers of state-of-the-art software packages for niche areas within the health sector in Australia and New Zealand. They have created a web-based data-collection tool for those certified colposcopists participating in re-certification and audit who wish to use an electronic format to enter their cases.

The software is designed to capture the requirements of the Standards in Diagnostic Colposcopy and Standards in Therapeutic Colposcopy and provide practitioners with a useful way to collect their data.

The C-QuIP data-collection web portal is now **LIVE** and ready to use.

Please take a look at our website at www.cquip.edu.au/data-collection-forms/web-portal.html for details on how gain access.

Ogilvie's syndrome



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In the puerperium, particularly following caesarean section, beware the postpartum distended abdomen.

Acute colonic pseudo-obstruction (ACPO) was first described in 1948 by the British surgeon Sir WH Ogilvie, who subsequently became the eponym of the condition. This acute surgical condition is classically described by massive colonic dilation in the absence of a mechanical cause. The exact pathophysiology is not fully understood, but if untreated the distension can result in rupture or ischaemic perforation of the bowel. We describe a recent case of Ogilvie's syndrome in a postpartum patient, review the literature on the condition regarding its diagnosis and management, and discuss the syndrome's relevance in obstetric practice.

Case report

A 43-year-old woman underwent an elective repeat caesarean section together with tubal ligation at 39 weeks gestation. The indication was maternal request for caesarean delivery and desire for a permanent method of contraception. The procedure was performed under regional anaesthesia (L3-L4 spinal block). There were no intra-operative problems noted.

During the first 24 hours, the woman used patient-controlled epidural anaesthesia (PCEA). This was removed on day two and the woman commenced regular oral analgesia. The patient remained well for the first 48 hours, but then reported spasmodic discomfort in the right upper quadrant of the abdomen and increased difficulty passing flatus with

no bowel motion for four days. There was no associated nausea or vomiting and vital signs were all within the normal range.

Examination revealed a hyper-resonant and distended abdomen, upper abdominal tenderness and reduced bowel sounds. A working diagnosis of ileus was made and a full blood count, urea and electrolytes, liver function tests, C-reactive protein (see Table 1) and urgent erect and supine abdominal x rays were ordered. The radiographs showed a 13cm dilated caecal colon and 8cm dilated transverse colon (see Figure 1). The patient was discussed during the consultant ward round and, as the diagnosis was strongly suggestive of Ogilvie's syndrome, the patient was transferred to the general surgical unit in the nearest hospital.

The surgical team ordered a pelvic and abdominal computed tomography (CT) scan that confirmed the initial radiological findings without any evidence of a transitional point; this made a functional cause of obstruction unlikely (see Figure 2). The surgical team initiated conservative management by restricting oral intake, providing intravenous hydration and inserting a flatus tube and regular enemas to encourage bowel activity. Over the next 24 hours, the patient started to pass flatus and decompress her bowel. The patient was discharged home on day six and given a follow-up appointment by the obstetric team for a debrief about her condition and its management.

Discussion and review

Since first being described in patients with retroperitoneal malignancy and involvement of the celiac plexus¹, ACPO has now been reported in a wide variety of clinical conditions. The largest case series² quotes a mortality rate of 15 per cent if diagnosed early and more than 40 per cent if the condition develops to the stage of bowel ischaemia.

The true incidence is unknown, but a large case series² estimated that ten per cent of ACPO cases occur in O and G patients. The importance of ACPO in obstetrics was underlined by the UK Confidential Enquiry into Maternal Deaths Report 2000–2002³, which reported three deaths from the condition during that triennium. Notably, after the condition was discussed in the CEMACH report, in the next triennium there were no reported deaths from the condition. In 2010, Rawlings⁴ published a case series of obstetric patients with Ogilvie's syndrome that demonstrated early recognition of the condition, and thus early management, had a clear benefit in terms of decreasing associated morbidity. The findings from CEMACH

Table 1. Haematological and biochemical results.

FBC	U/E	LFT
Hb 148 g/L	Urea 4.1mmol/L	Bili 16µmol/L
WC 16.9x10 ⁹ /L	Cr 46 µmol/L	ALT 16µmol/L
Neut 14.99x10 ⁹ /L	Potassium 4.2mmol/L	GGT 13U/L
PLT 172x10 ⁹ /L	Sodium 133mmol/L	Alk phos 151U/L
CRP 309	Bicarbonate 21mmol/L	Lipase 22U/L



Figure 1. Plain film abdomen showing distended caecum in Ogilvie's syndrome.



Figure 2. CT scan showing a coronal section of large bowel in a postpartum patient with Ogilvie's Syndrome.

and Rawling's paper suggest that clinician awareness of ACPO is an important strategy in minimising patient morbidity.

The pathophysiology of Ogilvie's syndrome is uncertain. There appears to be an autonomic dysfunction involving the parasympathetic and sympathetic innervation of the colon. The parasympathetic innervation of the colon is supplied by the Vagus nerve until the splenic flexure, thereafter the parasympathetic supply to the distal colon is from the sacral spinal cord S2-4. The sympathetic innervation of the colon is via the celiac and mesenteric ganglia. One hypothesis for the cause of ACPO is that transient parasympathetic impairment at the sacral plexus may cause atony of the distal large bowel (beyond the splenic flexure), which could result in functional obstruction.⁵ Alternatively, increased sympathetic drive can be stimulated by bowel distension that will impair motility (colo-colonic reflex) this can promote further distension, particularly if the ileo-caecal valve is competent.⁵ By whichever mechanism, the resultant large bowel functional obstruction results in significant volume depletion (third spacing) and gaseous distension, owing to the bacterial decomposition of the static intra-abdominal contents. The caecum has the largest diameter of the colon, hence it dilates more rapidly than the remainder of the large bowel. If left untreated the caecum can rupture because of mechanical stretching or undergo ischaemic necrosis, whereby the pressure in the caecal bowel wall impedes vascular blood supply, eventually resulting in perforation.

Clinical presentation in obstetrics

ACPO has been reported to occur in women having a vaginal delivery, instrumental delivery and also antenatally with complicated pregnancies.⁶⁻⁸ However, the most common clinical scenario seen is in women after caesarean section.⁶ Typically, patients present with symptoms of increasing abdominal pain (reported in 80 per cent of cases). In these patients, nausea, abdominal distension and failure to pass flatus or stools should raise suspicion of the condition. The onset of these symptoms may vary from as early as day two to 12 days after delivery.⁶

Diagnosis

Once Ogilvie's syndrome is suspected clinically, it should be confirmed radiologically. Colonic dilatation of more than 10cm is a significant marker of morbidity.^{5,8} A plain abdominal x ray

is the most useful investigation to perform, the radiation dose of this procedure is 0.7mSV, (equivalent to five mammograms).⁹ It is imperative to rule out a mechanical or other cause of obstruction or infection with *C. difficile* (toxic megacolon). Ogilvie's syndrome may mimic other conditions such as bowel perforation, bowel ischaemia¹⁰, sigmoid volvulus, peritonitis and so forth.⁶

Management

The management of Ogilvie's syndrome consists of conservative, medical and/or invasive procedures (see Figure 3).⁶

Conservative management

This is appropriate for patients with a caecal diameter of 10cm or less and has a success rate of 96 per cent.^{5,6} It involves intravenous hydration, restricted oral intake, correction of electrolyte disturbances, nasogastric tube insertion, rectal tube insertion for decompression and urinary catheterisation to monitor output. Medications that interfere with gut motility (for example, opiates and anticholinergics) should be avoided. A conservative approach may be trialled for one to two days. Response is measured subjectively by the patient's clinical condition and objectively by abdominal x rays.^{5,6}

Medical management

Neostigmine (a reversible acetylcholinesterase inhibitor that stimulates the colon) is the best evaluated medical treatment with published success rates of up to 50 per cent of patients.^{11,12} Neostigmine is recommended for patients who do not require urgent decompression or have any contraindications to its use (perforation, mechanical intestinal and/or urinary obstruction). The drug can be given as a parenteral injection or as an infusion. Signs of resolution of ACPO may be observed within 30 minutes of administration, but usually more than one dose is required.⁶

Invasive procedures

Colonoscopic decompression is the third-line management for Ogilvie's syndrome. It is recommended in patients where conservative and medical treatment has failed. It has a reported success rate of 88 per cent.¹³ Complications include failure to decompress, relapse (40 per cent) and perforation (three per cent).^{5,6,14} Surgical therapy is the last line of treatment for Ogilvie's syndrome. It is indicated for patients who fail conservative,

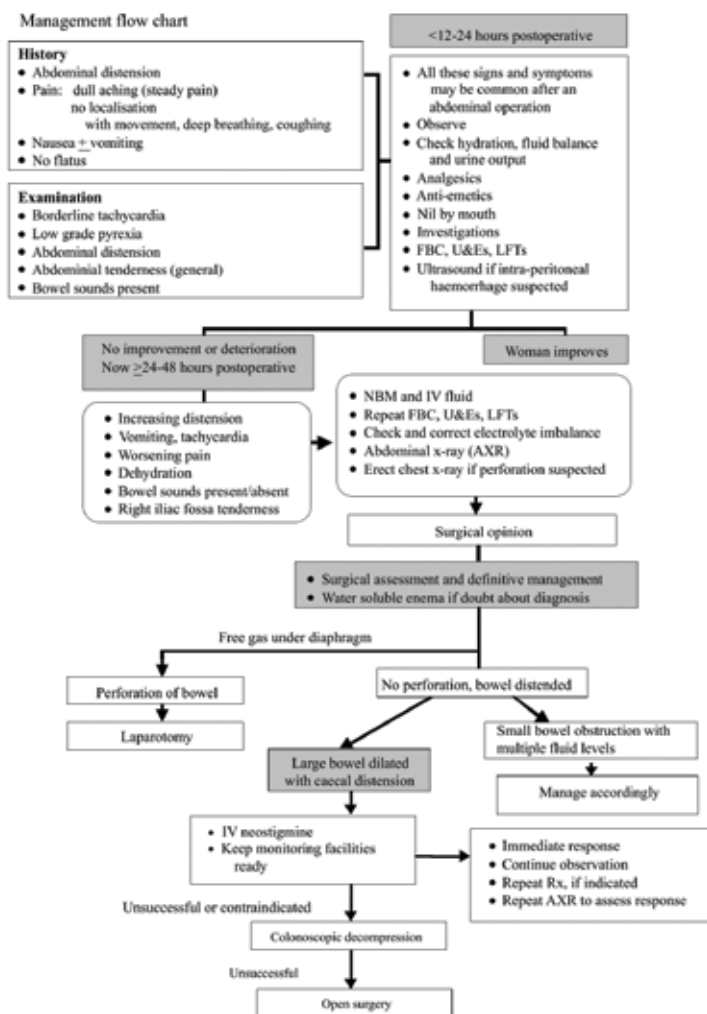


Figure 3. Treatment algorithm for Ogilvie's syndrome. Reproduced with permission from The Obstetrician and Gynaecologist.⁶

medical and endoscopic decompression, or for the critically ill with complications of Ogilvie's syndrome such as perforation or bowel ischaemia. It usually involves resection of the damaged bowel and stoma placement.⁶ Surgical treatment has a high morbidity, with a mortality rate of 30 per cent.²

Follow-up

Previously healthy mothers who suffer from Ogilvie's syndrome may require significant counselling and psychological support, this is particularly pertinent for patients who experience a delay in diagnosis or who have significant complications from ACPO. A discharge plan with a follow-up to debrief the patient and her family is sensible.

Conclusion

Ogilvie's syndrome is a rare, but important, diagnosis to be aware of in obstetrics owing to its high morbidity and mortality. Any woman with abdominal distension in the early puerperium should be thoroughly reviewed and ACPO considered. A plain abdominal x ray is the most useful investigation to perform.⁵ If diagnosed early, conservative management is often successful and morbidity is minimal.

Acknowledgement

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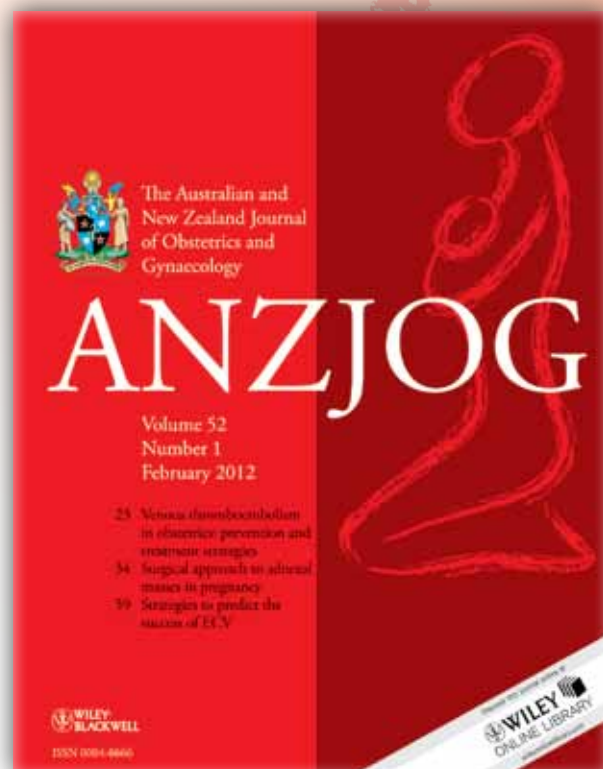
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Q&a

Q&a attempts to provide balanced answers to those curly-yet-common questions in obstetrics and gynaecology for the broader *O&G Magazine* readership, including Diplomates, Trainees, medical students and other health professionals.

Q *A woman in the antenatal clinic has had two previous caesarean sections, the first for obstructed labour, the second a planned elective repeat caesarean. Both were uncomplicated. She presents with her doula at 34 weeks gestation after an uncomplicated antenatal course and says that unless a trial of vaginal delivery is undertaken she will attempt a homebirth. How should her care be managed?*

A/Prof John Svigos AM
FRANZCOG, MBBS,
DRCOG, FRCOG

a

After a cordial greeting and an introduction to the doula, we should open with a discussion of the patient's reasons

and expectations of attempting a planned vaginal birth, but in a positive manner, informing her of the systematic review of this precise clinical situation.¹

In this study the successful vaginal delivery rate in women planning a vaginal birth after two previous caesarean sections (VBAC-2) was 71.1 per cent, with a uterine rupture rate of 1.36 per cent, a hysterectomy rate of 0.55 per cent, a blood transfusion rate of 2.01 per cent, a neonatal unit admission rate of 7.78 per cent and a 0.09 per cent chance of perinatal asphyxial injury/death.

The maternal morbidity for VBAC-2 was comparable with repeat caesarean section (RCS) after two previous caesarean sections, while the neonatal morbidity data were too limited to draw valid conclusions.

In addition to the above results, the need for maternal intravenous access, maternal-fetal monitoring, time intervals for serial vaginal examinations and the selected parameters of the progress of labour should be discussed in detail² to ensure the patient and her doula are aware of these requirements, which may or may not sit well with the patient's desire for a 'natural birth', along with the precise implications of uterine rupture and the maternal and neonatal consequences of such a complication occurring during labour.

A policy of awaiting the spontaneous onset of labour would normally be instituted as not only will this be more likely to be associated with successful vaginal birth³, but also the difficulties in trying to induce labour and its greater chance of scar rupture and caesarean section may be avoided.^{4,5}

If induction of labour is indicated for an obstetric complication or if the pregnancy progresses past the expected date of delivery then the clinical situation needs to be reviewed in its entirety and the way forward agreed upon with the knowledge that induction of labour in the face of an 'unripe' cervix with VBAC-2 may only have a 25 per cent successful vaginal birth rate or less with at least a 4.08 per cent risk of uterine rupture.²

Meaningful communication with the doula is an important aspect of the management and this should be straightforward if the doula adheres to the stated ethos of the Australian Doula College⁶ that: 'a doula, or birth attendant, is a woman offering non-medical support and information to parents in pregnancy, childbirth and the postnatal period.'

However, a number of doulas adopt the role as the negotiator of the obstetric and midwifery care between the patient and her obstetric and midwifery attendants, which adds another dimension in providing compassionate, dedicated and professional care and can lead to tension, mistrust and confusion.

The delineation of responsibilities needs to be discussed and decided upon well before the onset of labour in order to avoid disappointment and frustration primarily for the patient and her partner, but also for the midwifery and obstetric staff.

The American College of Obstetricians and Gynaecologists advises that doulas acting beyond the role of patient support by providing medical advice should be appropriately advised out of the presence of the patient and that professional associations/institutions should have policies in place to address such issues.^{3,7}

If the above arrangements, both in relation to her care and the role of her doula, do not prove to be acceptable to the patient despite documented, repeated discussion then we may have to accept that the patient may attempt a homebirth and the public hospital providing her antenatal care will have a duty of care to provide emergency care, after transfer, in the sad event of an obstetric/neonatal complication occurring during her labour or after her delivery at home.

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An invitation to join PSRH to support reproductive health in the Pacific

The Pacific Society for Reproductive Health (PSRH) is a Charitable Trust, registered in New Zealand in 2007. Our aim is to improve reproductive, neonatal and perinatal in the Pacific by developing the Pacific workforce. Our objectives are:

1. To establish a supportive network of health professionals involved in reproductive health in the region
2. To use this network as a support mechanism for exchange of ideas, knowledge and experiences, and other resources thereby contributing to the improvement of reproductive health services and programs
3. To foster continuing professional development for Pacific Island health professionals in order to enhance quality of care in reproductive health and workplace satisfaction.
4. To establish professional linkages with reproductive health expert groups through affiliation with groups such as nursing and midwifery bodies, obstetrician and gynaecological experts and other NGOs working with and across the Pacific Island Countries.

Membership

Our members are clinicians and public health professionals who have a common interest in the health of women and children. Our multidisciplinary membership includes midwives, nurses, doctors and other health professionals from 15 Pacific Island nations as follows: American Samoa, Australia, Cook Islands, Federated State of Micronesia, Fiji, Kiribati, New Zealand, Niue, Palau, Papua New Guinea, Samoa, Solomon Islands, Tonga, Tuvalu, Vanuatu.

Visit the PSRH website to see contact details for your PSRH country liaison officer <http://www.psrh.org.nz/contact.aspx>. Your country liaison officer will be able to assist with opportunities through PSRH, membership or any other enquiries.

Keep tabs on what's happening and register your interest in attending the PSRH meeting with Frances Turrell at eo@psrh.org.nz, or your PSRH country liaison officer.

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How do I join?

An application form is available to download from the membership section on our website. <http://www.psrh.org.nz/membership.aspx>. Please fill in and send to the PSRH secretariat by email eo@psrh.org.nz or fax +64 9 5235253. For members in Pacific island countries, please contact your PSRH Liaison officer to make payment if this is more convenient.

We are keenly aware of the need to upgrade our membership lists, in Australia and New Zealand in particular, and we encourage past members, with whom we have lost contact, to renew their membership to support PSRH. As ever, we are keen to welcome new members to PSRH in the common interest of collaboration and networking between sexual and reproductive health professionals in our region.

Journal Club



Had time to read the latest journals? Catch up on some recent O and G research by reading these mini-reviews by Dr Brett Daniels.

Nitrofurantoin in pregnancy

Urinary tract infection is common in pregnancy and a frequent reason for with antibiotic treatment. Nitrofurantoin has been used for many years and is generally thought to be safe in pregnancy; however, there have been some reported associations with malformations, including enophthalmia and cleft palate.

Goldberg et al. report a large-scale retrospective cohort study examining pregnancy outcomes in women exposed to nitrofurantoin in the first trimester. The authors analysed 105 000 pregnancies in an Israeli hospital between 1999 and 2009, including 1112 terminations for medical reasons. Of these, 1329 women had been exposed to nitrofurantoin in the first trimester of their pregnancy. Data on malformations were gathered from ultrasound of fetuses aborted for malformations, from newborn examinations and from infant hospitalisations up to 12 months of age. The rate of major malformations was 5.7 per cent in the nitrofurantoin group and 6.2 per cent in the non-exposed group. There was no increased risk after adjustment for maternal age, parity, ethnic group, pre-gestational diabetes, medical pregnancy termination and smoking during pregnancy. The authors concluded that nitrofurantoin does not increase fetal malformation if used in the first trimester.

Goldberg, O, Koren, G, et al. Exposure to nitrofurantoin during the first trimester of pregnancy and the risk for major malformations. *Journal of Clinical Pharmacology*, 2013, 53, published online.

IUDs and dysmenorrhea

Intrauterine devices (IUDs) containing either copper or levonorgestrel (Mirena) are widely used throughout the world. This Swedish longitudinal population-based study reports on the association between IUDs and dysmenorrhoea. The study is based in Gothenburg and, in 1981, randomly selected one in four of all 19-year-old women living in the city to receive a questionnaire regarding contraception, reproductive history, menstrual symptoms and other health data. They then received similar questionnaires every five years. Similar recruiting was performed in 1991 and 2001, except that one-in-three sampling was used. Women recruited in 1991 and 2001 also received questionnaires at five-year intervals. The authors report in 1981 91 per cent of invited women agreed to participate in the study, with rates of 82 per cent and 77 per cent in 1991 and 2001. In 2006, 54 per cent of the women recruited in 1982 were still participating, 25 years after their initial contact.

The study reported that IUD use in their population ranged from 16 per cent of women at 29 years old to 39 per cent at 44 years old. Copper-containing IUDs were more common in the younger women while levonorgestrel IUDs were more common in the older women. As far as dysmenorrhoea symptoms were concerned, women reported a significant reduction in dysmenorrhoea as they became older or had children. They did not report a significant change in dysmenorrhoea when using the copper-containing IUD compared to other contraceptives. They did, however, find both the levonorgestrel IUD and the combined oral contraceptive pill were associated with a reduction in dysmenorrhoea when compared to other contraceptive methods.

Lindh, I and Milsom, I. The influence of intrauterine contraception on the prevalence and severity of dysmenorrhoea: a longitudinal population study. *Human Reproduction* 2013, 28: 1953-1960.

Long-term outcomes of endometrial ablation

Endometrial ablation is the permanent destruction of the endometrium intended to reduce menstrual bleeding. First-generation techniques included rollerball ablation and laser ablation under direct hysteroscopic vision. Second-generation techniques are now more common and include thermal balloon (for example, Thermachoice, Cavaterm, Thermablate), microwave (Microsulis) and bipolar radiofrequency ablation (for example, Novasure). In many cases, endometrial ablation is attractive to women seeking to reduce menstrual flow while avoiding the side effects of medication or hysterectomy.

This meta-analysis focused on recent (since 2010) randomised controlled trials (RCTs) or cohort studies examining the outcome of second-generation endometrial ablation, at 12 months or more post-procedure. Daniels identified 13 studies, including four RCTs. Results indicated a higher rate of amenorrhea in the bipolar radiofrequency ablation (ranged from 55–97 per cent amenorrhea from 4.5 to eight years post-procedure in different studies) compared to thermal balloon techniques (range from 13–58 per cent amenorrhea from two to five years post-procedure). Rates of patient satisfaction were only reported for thermal balloon and radiofrequency ablation techniques, but were generally high, ranging from 60–93 per cent. The author also reported that around 20–25 per cent of women undergoing endometrial ablation have a second procedure, either a repeat ablation or a hysterectomy. She reported that 6–11 per cent of women having a radiofrequency ablation after five years had repeat intervention, while the comparable rates are 19–25 per cent for thermal balloon ablation.

Endometrial ablation is not intended as a sterilisation technique, with women recommended to use contraception. However, pregnancies are reported and as this study reports they are associated with poor obstetric outcomes. One study identified 123 pregnancies following endometrial ablation. Nearly half were terminated on maternal request while of the 64 that continued 28 per cent miscarried, 16 per cent had preterm rupture of membranes and 31 per cent delivered prematurely. Placental adherence was a complication in 17 of the 64 pregnancies and ten pregnancies resulted in hysterectomy.

In summary, endometrial ablation is an effective treatment for heavy menstrual bleeding for many women. The current review showed an increased rate of amenorrhea for the radiofrequency ablation technique compared to the thermal balloon technique, with both techniques having high rates of patient satisfaction. It is very important that women are aware of the need for contraception following endometrial ablation, given the poor pregnancy outcomes in women who do become pregnant following ablation.

Daniels, JP. The long-term outcomes of endometrial ablation in the treatment of heavy menstrual bleeding. *Current Opinion in Obstetrics and Gynecology* 2013, 25: 320-326.

Letters to the editor

The drunk consultant

This excellent and timely article, *O&G Magazine* Vol 15 No 2 Winter 2013, overlooks one important problem: the power imbalance.

In the 1950s, I was a registrar in the UK and for my last 12 months I worked for a consultant who was nearly always affected by alcohol after 6pm. I had become used to taking 99 per cent of the responsibility for after-hours emergencies. One day, at about 2am, I admitted a patient with a rare and life-threatening emergency in mid-pregnancy. After much argument on the telephone, the consultant came to see her. He was obviously the worse for wear and there was a confrontation.

I had already been successful in obtaining a teaching hospital senior registrar appointment. A few days later, the consultant told me that he would write to Prof X and that would kill my career stone dead! He also refused to sign my book for the MRCOG.

Fortunately, Prof X was a reasonable man and I did not suffer the threatened fate. However, I still feel that sickness in the gut when I remember this incident. In those days, there was no clear procedure in UK hospitals.

It is now well-known that whistle-blowers tend to suffer a negative effect on their careers. I do not know the answer to this problem, but consider that the authorities should bear in mind the power imbalance.

Dr David Blackledge
MA, FRCOG, FRANZCOG

Experience-based medicine

Since getting the MRCOG, in 1968, there have been some radical changes in our speciality; some good, some bad. As an optimist, I would prefer to reflect on the good ones. In no particular order, the following are what I judge as the top developments in the speciality:

- Ultrasound in obstetrics (I am not so sure about gynaecology): it is wonderful to be certain of a patient's due date, particularly if they become pre-eclamptic; be able to localise the placenta accurately without radioisotopes; not to have to worry about being caught by the undiagnosed twin or triplet; and avoid the stress of delivering a non-survivable malformation, such as anencephaly (and the miserable business of its euthanasia, usually with a relaxant from the anaesthetic tray).
- Polyglyconate sutures are one of the unsung heroes of modern surgery. When I was training, it was not unusual when tying off the uterine artery for the catgut to snap. How beautiful to have sutures that are virtually impossible to break and absorbed when they are no longer needed.
- When cardiotocography (CTG) came in, I remember remarking to my colleagues that, used correctly, it would lower the caesarean section rate. Alas, many an unnecessary caesarean

section has been done using a dubious CTG tracing as the excuse, particularly with syntocinon augmentation. For all of that, a reassuring CTG can be a great stress reliever.

- Before the introduction of the LLETZ/LEEP loop, cervical dysplasia was treated by either radial cautery or cone biopsy. This gave us plenty of cases of cervical stenosis (from the former) and cervical incompetence (from the latter) to manage.
- The Mirena intrauterine contraceptive device gets my vote for the greatest innovation from the last decade or so, particularly with world overpopulation probably the greatest threat we face. Its side-benefit of reduction of menstrual flow has also proved beneficial.
- Before laparoscopy, diagnosis of, for example, uterine adnexal disorders could only be done with confidence by laparotomy or posterior colpotomy. In addition to the latter, many of us got quite good at tying tubes through the anterior fornix in an effort to avoid laparotomy.
- In 1972, when Depo-Provera was introduced to Australia, everyone welcomed the incredibly reliable, safe and reversible contraceptive. It took only a few years to realise its use in the treatment of dysmenorrhoea unresponsive to the oral contraceptive pill and its benefit on the two big oestrogen-dependent disorders, endometriosis and recurrent candidiasis.
- Gynaecological oncology: we all knew the morbidity of radical hysterectomy and radical vulvectomy when done by the occasional operator, particularly with the radiotherapy of the era. The introduction of modern chemotherapy for ovarian cancer created a new dimension in its management. It was a relief to be able to hand it over to someone who could do the job properly.

Dr Graeme Dennerstein
RFD, MBBS, FRCOG, FRANZCOG

Notice of Deceased Fellows

The College was saddened to learn of the death of the following Fellows:

Dr James Doig Thomson, of New Zealand, on 20 May 2013
A/Prof Kenneth Margolis, QLD, on 12 July 2013
Dr John Roger Doig, of New Zealand, on 23 July 2013.

Rare incubator acquired

Gráinne Murphy
Museum Curator

The RANZCOG Museum has a new, rather intriguing acquisition. A Watson Victor neonatal incubator, c1950s to early 1960s, was bought at auction in Melbourne recently.

The incubator was part of a rare collection of medical, dental and pharmaceutical objects belonging to a tourism business, Kryal Castle, near Ballarat, Victoria. Kryal Castle is a replica medieval castle and used to host medieval banquets and jousting tournaments. Bizarrely, it included a medical museum that housed the collection of 19th- and 20th-century medical, dental pharmaceutical artifacts that eventually formed 300 lots at the Leski auction in May of this year. Imagine the shock of mead-satiated tourists, fresh from witnessing the jousting, to have an encounter with the medical museum, engaging with such items as a mortuary specimen bucket and shock-therapy machines. Kryal Castle was offered for sale in 2007, but failed to sell. Regrettably, it seems the museum records were discarded, so the provenance of the neonatal incubator and many other items in the Leski auction, has been lost.

The incubator was probably made in the 1950s or the early 1960s. A name plate on the object inscribed 'Australia/Watson Victor/New Zealand' indicates this period, as the company changed business names frequently, assisting in dating their products. Watson Victor was a well-known medical technology business, most famous for its

radiology equipment. The incubator's materials are also a clue to its time of manufacture. The incubator's walls are of laminated asbestos sheeting, with polished aluminium strips at the top. A dial and power switch are made of Bakelite. As hard plastic quickly superseded Bakelite in the 1960s and aluminium was a popular material by the 1960s, manufacture was most likely of that period. Another nameplate indicates the incubator was made in Melbourne by the Aeronautical & Industrial Lighting Co in North Road, Carnegie.

A plea went out to RANZCOG Fellows with an interest in medical history as well as to CHAHM, an online discussion group of those working with health and medicine collections across Australia and New Zealand, for assistance to learn more about the incubator. The enquiry has drawn many responses, including from Judith Cornell, Honorary Archivist, College of Nursing, Sydney, who recalled seeing this type of incubator. She worked at many hospitals and she thinks she most likely saw it in use at the Brisbane Women's Hospital, where she was doing midwifery in 1960. At this time there was no neonatal intensive care unit. The incubator would have been in the labour ward, perhaps there would have been one or two, certainly no more than that. She recalls the baby incubator being used to transfer premature babies to theatre.

The RANZCOG Museum's incubator is not complete, there is no cover. Judith Cornell remembers a dome-shaped Perspex top with two hand holes. In time, I will determine the shape and dimensions of the cover and have a reasonable replica made. If you have any additional information regarding this object or you would like to donate to the RANZCOG Museum collection, please contact me: gmurphy@ranzco.edu.au +61 3 9412 2927.



The baby incubator was acquired for the RANZCOG Museum collection.



The Watson Victor name plate, shown above, helped to date the incubator.

RANZCOG Research Foundation

Recipients

Prof Jonathan Morris
Chair, Grants and Scholarships Committee

Prof Caroline de Costa
Chair, Board of Research Foundation Directors



ASGO International Travelling Fellowship 2012

Dr Jegajeeva Rao

A review of High-Risk Human Papillomavirus DNA Testing as a Test of Cure in Patients Previously Treated for Cervical Pre-Invasive Diseases

The Fellowship supported my research, which was a retrospective review of ten years' data on the usage of HPV DNA testing (Hybrid Capture II) as a test of cure for patients treated for high-grade Pap smears. My Fellowship was under the supervision of Prof Neville Hacker (Director of Gynaecological Cancer Centre) and Dr Michael Campion (Director of Colposcopy and Pre-invasive Diseases Unit). Apart from the research project, I also participated in the colposcopy and gynaecological oncology clinics, operative sessions, ward rounds, Tumour Board meetings, formal teaching sessions, CME/CPD activities and social activities within the unit/centre.

The retrospective review ended up being a large project, which was impossible to achieve within the specified two months and single-handedly, as I was also pursuing clinical training and a PhD at UNSW concurrently. The entire review required an Area Health Services low/negligible risk ethics approval, help of a co-researcher to sieve through the data of more than 10 000 entries of cervical pathology and services of a professional biostatistician.

However, the final analysis proved to be very gratifying with a set of results which, upon literature review, I believe is the largest dataset for such study from a single unit/operator. The review is still work in progress. The credit of authorship is not mine alone, but also goes to Prof Neville Hacker (project supervisor), Dr Michael Campion (colposcopist/operator), Dr Bayzidur Rahman (biostatistician), Dr Catherine Camaris (pathologist) and Ms Joanne Tan (co-researcher). I am hoping to be able to publish two papers in international peer-reviewed journals from further analysis of the data and due acknowledgement will be made of the 2012 ASGO International Travelling Fellowship.

Taylor-Hammond Research Scholarship 2012

Dr Justin Daly

The Causes and Consequences of Obstetric Related Pelvic Floor Trauma

We investigated the incidence, risk factors and sequelae associated with obstetric trauma involving the anal sphincter complex and puborectalis muscle, known to be a risk factor for recurrent prolapse. Our analysis of 20 years of perinatal data demonstrated an obstetric anal sphincter injury (OASIS) rate of 1.7 per cent up to 2005, rising to 7.2 per cent in primiparous women between 2005 and 2012. Associated risk factors were Indian ethnicity (OR 3.4), nulliparity (OR 4.1), forceps (OR 4.0) and ventouse (OR 2.0) with Caucasian ethnicity (OR 0.6), induction of labour (OR 0.7) and epidurals (OR 0.8) being protective. These insights led to development of a guideline to prevent OASIS, the results of which will be assessed. We have just completed recruitment for a transperineal ultrasound study of 100 women with and without OASIS to investigate the incidence of puborectalis injury in these groups along with a validated pelvic floor symptom questionnaire. These results will be presented internationally this year and inform whether such women experience higher rates of pelvic floor dysfunction and should be offered early intervention. I'd like to thank the RANZCOG Research Foundation for the opportunity to increase local knowledge and develop management strategies to minimise this significant cause of long-term pelvic floor morbidity.

Mary Elizabeth Courier Research Scholarship 2010-2012**Dr Viola Heinzelmann-Schwarz**

Evaluation of an Anti-glycan Antibody Panel as New Diagnostic Signature in Serous Ovarian Cancer Patients

The Scholarship was used for the salary of a research assistant, studying the role of anti-carbohydrate antibodies in blood and ascites of ovarian cancer patients as well as healthy control patients. Within three years the team has built up a biobank of 800 patients and six tissue microarrays, and has achieved 12 publications. The group has received so far a total of AU\$2.1 million in funding, enabling the recipient to establish an Ovarian Cancer Research Group within the Lowy Cancer Centre at the University of New South Wales. Their findings, which were a world first result, indicate a role for the P blood group system in the development of ovarian cancer and lead towards a new method for the diagnosis, prognosis and potential therapy in these patients.

Glyn White Research Scholarship 2011-2012**Dr Tamara Yawno**

Novel Cell Based Therapy for the Treatment of Perinatal Brain Injury

Cerebral palsy (CP) is the most common cause of childhood disability. In Australia, a baby is born with CP every 15 hours. Until therapies are developed to either protect the developing fetal brain before birth, or repair the brain soon after birth, there will be no cure for most cases of CP. Currently, all postnatal therapies are designed to reduce the symptoms of CP rather than preventing the progression of brain injury.

Stem cells offer the potential for great therapeutic benefit for a number of debilitating human conditions. Human amnion epithelial cells (hAECs) are easily accessible, obtained from the discarded human placenta, and therefore do not have the limitations of adult and embryonic stem cells for their potential clinical application. This project has been designed to address whether hAECs administered to a fetal sheep following induced fetal inflammation, are able to reduce fetal brain injury.

We have shown for the first time that hAECs reduce brain injury in response to inflammation. The likely mechanism of action is via anti-inflammatory effects, preventing the breakdown of the blood brain barrier (an important barrier which prevents toxins from entering the brain). Thus, we have shown that the administration of hAECs protects the developing brain when administered concurrently with the initiation of intrauterine inflammation.

Brown Craig Travelling Fellowship 2012**Dr Justin Daly**

Thanks to the Brown Craig Fellowship, I spent six weeks with Mr Abdul Sultan and Ms Ranee Thakar at the Croydon University Hospital Pelvic Floor Unit specialising in obstetric anal sphincter injury (OASIS) management. The perineal clinic is structured to provide comprehensive anorectal assessment and multi-disciplinary management for most women in a single visit and is supported by a data collection system, enabling the collection of ten years of prospective postnatal and antenatal data. The clinic provides direct feedback to the labour ward to improve prevention, recognition and repair of injuries, it also supports research and training course development. The overall rate of OASIS was 4.6 per cent, with 90 per cent diagnosed correctly and a residual defect rate of 12 per cent. With comprehensive antenatal assessment in subsequent pregnancies, 85 per cent of women delivered vaginally, with only 15 per cent advised or choosing to have a caesarean section, resulting in no deterioration in short-term anorectal function. These findings have been presented at the 2012 RANZCOG ASM, 2012 International Urogynecological Association (IUGA) meeting and will be at the 2013 IUGA meeting. This fellowship has assisted in developing a multidisciplinary OASIS clinic at Royal Prince Alfred Hospital, providing women with the best available information and options to safely minimise anorectal dysfunction.

Capacity building and teamwork in the Pacific

Carmel Walker
Asia-Pacific Committee
Senior Coordinator

RANZCOG is working collaboratively to develop leadership, and improve communication and teamwork in Pacific island countries.

On 12 July 2013 a PSRH/RANZCOG Midwifery Leadership Development Seminar Day was held in Apia, Samoa, as a component of the Pacific Society for Reproductive Health (PSRH) Biennial Meeting. The seminar day was developed as an offshoot of the successful RANZCOG Pacific Midwifery Leadership Fellowship Program (PMLFP) conducted in Sydney, Australia, which is funded by AusAID Australia Awards Fellowships (formerly called the Australian Leadership Awards Fellowship Program). The objective of the seminar day was to extend the impact of the PMLFP and share outcomes from the program with a wider group of Pacific midwives. This particular objective was undertaken through a Practice Improvement (PI) Marketplace, where 12 past Brian Spurrett Fellowship (BSF)/PMLFP awardees presented information on how they have developed a PI project, the progress made and what results have been achieved.

The PMLFP has been running since 2010, following on from the earlier BSF Program that commenced in 2004. The Australia

Awards Fellowships currently fund 16 PMLFP Fellowships a year and a number of additional Fellowships are funded by the RANZCOG Brian Spurrett Foundation. Since its inception, 52 Pacific midwives have undertaken a Fellowship visit through the BSF or PMLFP at Liverpool Hospital, Nepean Hospital or Middlemore Hospital, Auckland, New Zealand.

During the Midwifery Leadership Development Seminar Day, RANZCOG President Prof Michael Permezel visited the PI Marketplace and said: 'I was impressed by the remarkable achievements and results that past BSF and PMLFP Fellows had achieved in their PI projects on return to their home countries. The marketplace and presentations were informative, inspiring and addressed key issues in safe delivery of maternity services in the Pacific countries. There were many fine stories from dedicated individuals doing excellent work with the resources they have available.'



RANZCOG President Michael Permezel visiting the PI Marketplace.

One such presentation was the introduction and implementation of a birth preparedness plan/complications readiness plan (BPP/CRP) in Fiji. This has been supported by the Fiji Ministry of Health and AusAID, and developed as a training package for community health nurses and other relevant maternity providers, to improve maternal and perinatal mortality rates. Other projects presented included the introduction of a postpartum haemorrhage kit in the labour ward, a DR C BRAVADO Stamp to document cardiotocography interpretation and a running sheet of patient management to ensure that care is documented in the labour ward. An important piece of work undertaken at the Colonial War Memorial Hospital in Suva was a study into gender-based violence (GBV), to gather information on incidence, timing during the pregnancy, type of violence, ethnicity and the relationship of the abuser to the victim. Recommendations arising from the study included the need to raise community awareness about the issue of domestic violence as a public health problem, and how this might occur through media, grassroots campaigns and educational programs. It is hoped that this project will be shared with a wider audience at the next PSRH meeting as the incidence of GBV continues to be a disturbing factor for Pacific island countries and the health workers who care for victims of GBV.

Past PMLFP Fellow Sr Mary Magabe of Mendi Hospital, provided an overview of her research project on 'Assessing the knowledge, use and practices of family planning by child-bearing age women in the Southern Highland Province of Papua New Guinea'. Since her Fellowship, Mary has gone on to undertake a Masters in Midwifery at Flinders University, South Australia, having received the prestigious Allison Sudradjat Award as the top female applicant in Papua New Guinea (PNG) for the AusAID scholarship in 2011.

A project to learn about the perception of mothers regarding the six-week postnatal check in Vila Central Hospital (VCH), Vanuatu, was undertaken late last year, with results revealing that 40 per cent of mothers did not know anything about postnatal checks, 44 per cent thought postnatal checks were for family planning and 16 per cent thought physical examination was the reason for a postnatal check. Reasons for non-attendance included a perceived fear of cancer being caused by contraceptives and 12 per cent of mothers reported partners had prevented them from attending postnatal checks. Overall results had pointed to no or ineffective health education services to mothers during antenatal visits. As a result, discussions are now underway to design an effective health education package for mothers during antenatal visits at VCH.

With the focus on College programs in the Pacific being to build caring, efficient, quality teams and maximising scarce human resources to provide quality, compassionate care to achieve the best results for women and their babies, it was gratifying to see a woman-centred approach being contextualised for the Pacific in practical ways. An example of this was a survey underway in the Birthing Unit at the National Referral Hospital (NRH), Honiara, to ascertain the perceived standard of customer service and, from the data collected, the formulation of improvements to the quality of customer service.

RANZCOG Associate Member Dr Leeanne Panisi, O and G specialist and Head of Unit at the National Referral Hospital, Honiara said, 'Our hospital has benefited from the attendance of a number of our midwives in the Pacific Midwifery Leaders Fellowship Program. These midwives are proactive team members of our obstetrics and gynaecology unit who hold key positions in the department. I've been



The PI Marketplace encouraged attendees to learn from each other's work and share ideas.



PMLFP Fellows and the program coordinators from Sydney together with RANZCOG staff at PSRH/RANZCOG Midwifery Leadership Development Seminar Day that was held in Apia, Samoa.

pleased to see the increase in their communication, critical thinking and management skills. The program enables our Pacific midwives to improve in these areas and, in turn, improve the standard of care for the women of the Pacific.'

PSRH President Dr Alec Ekeroma said: 'PSRH sees the value and importance of building the capacity of midwifery leaders in the Pacific island countries, and the opportunity for the midwives from the Pacific to join with Sydney midwives in presenting the Midwifery Leadership Development Seminar Day was a good opportunity to practice leadership and communication skills through a range of practical exercises. PSRH looks forward to including presentations from these and other PI and research projects from leading Pacific midwives in future PSRH meetings. Well done to all who made an active contribution.'

A capacity-building vehicle to provide in-country support through networking and information sharing between senior midwives has been established through a PMLFP alumni association in PNG and Fiji. It is expected that branches of the alumni association will be set up in Solomon Islands and Samoa in the near future. PSRH and RANZCOG will support and assist the role and function of the Pacific Leadership alumni groups as required. Australia Awards Fellows are also automatically members of the Australia Awards Alumni, giving them access to a global professional network. These initiatives demonstrate growth and maturity in midwifery leaders in the Pacific and, together with other initiatives promoted by PSRH, RANZCOG sees this as a tangible way to support teamwork and capacity building for the medical and midwifery workforce in the Pacific region.

Acknowledgements

RANZCOG is pleased to acknowledge support for the PSRH/RANZCOG Midwifery Leadership Development Seminar Day from AusAID International Seminar Support Scheme (ISSS). The Liverpool and Nepean Hospitals are acknowledged for their key contribution to the PMLFP in Sydney and the seminar day in Apia, through staff Christine Stephens, Richard Gilfillan, Shushila Boswell and Elizabeth Edwards. Counties Manukau District Health Board is acknowledged for its contribution to the BSF program in Middlemore Hospital, Auckland, in particular, Sanne Wesseling.

Finally, special acknowledgement is made to the following PI Marketplace stallholders and seminar facilitators who contributed to the initiative: Srs Aliote Galuvakadua, Salote Tukana, Sera Nauqe, Asena Lolohea, Tagi Druku and Lautaimi Lepolo from Fiji; Srs Mary Magabe, Maria Posanek, Mary Kililo and Mr McKenzie Maviso, from Papua New Guinea; Srs Ellery Hivu and Anita Maepioh, from Solomon Islands; Sr Sera Toalia, from Vanuatu; and Srs Asenati Tuilaépa, Tapuni Tanielu-Suesue and Avaia Tuilaepa-Lautusi, from Samoa. Thank you to all involved.

Correction

O&G Magazine Vol 15 No 2 p68. Text should have read 'Antibiotic cover needs to be initiated at least four hours prior to delivery in order to have the full protective effect.'

Coming together to meet common goals

Dr Alec Ekeroma
FRANZCOG
President
**Pacific Society of
Reproductive Health**

The Pacific Society of Reproductive Health (PSRH) 10th Biennial Conference, held in Apia, Samoa, 9–12 July, was a huge success with more than 270 participants from 15 countries of the Pacific.

The conference was opened by the Samoa Minister of Health, Hon Tuitama Dr Leao Tuitama who, in his speech, acknowledged representatives of sponsors who made the conference possible: AusAID, NZAID, RANZCOG, the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), the World Health Organisation (WHO), Strengthening Specialised Clinical Services in the Pacific (SSCSiP) and the Royal Australasian College of Surgeons (RACS). He also acknowledged the presence of the International Confederation of Midwives (ICM), the New Zealand College of Midwives (NZCOM) and the Australian College of Midwives (ACM).

He went on to say: 'Governments have limited resources to meet the increasing demand for more and better services on the back of the increase in non-communicable diseases. However, ideas and innovation have no limitations where there is a desire by peoples to rise above the mediocrity of thought and action. I am told that you have some of the best brains in reproductive health in this conference. Therefore, I am sure the discussions will be engaging, if not heated, and I am excited of the prospect of receiving wise recommendations from your deliberations.'

The Brian Spurrett Oration was delivered by Prof Pat Brodie, former President of ACM, and the first midwife to deliver the oration, who said: 'The most important assumption, and one that we need to become very clear about, is that the impact that regulated, competent, respectful midwives make to positive maternal and infant health outcomes is seen as central to the efforts to accelerate progress towards the achievement of Millennium Development Goals 4 and 5.'

The key areas discussed were: family planning, sexually transmitted infections, maternal and child health, partner violence, strengthening health systems and professional development.

Dr Rufina Latu, from WHO, said at the workforce development session: 'Issues raised by specialist trainees in Fiji and by young specialists in the islands have made us aware of the importance of professional training and mentoring to make sure we have multifunctional and multi-skilled mature specialists running health services in the Islands.'

Prof Michael Permezel, President of RANZCOG, said: 'it is important that trainees are trained, supported and supervised appropriately in order to meet the

needs of the communities they will be serving. The Asia Pacific Committee of RANZCOG and PSRH can work together to explore sustainable solutions.'

The conference was preceded by a three-day Pacific Emergency Obstetric Course (PEmOC) that was attended by more than 25 participants, mainly from the Samoa Health Service, and led by Dr Miriam O'Connor, assisted by Profs Glen Mola and Pat Brodie, Drs Sharon Bolitho, Martin Sowter and Francis Maru. Four other workshops were held on the last day of the conference: research and clinical audit; ultrasound scan; suturing and obstetric anal sphincter injuries; and the Pacific Midwifery Leadership Fellowship Program Workshop.

The PSRH President's Medals, recognising outstanding service to the profession in the Pacific islands, were awarded to Dr Wame Baravilala and Prof Glen Mola. The awards for the best research papers by a Pacific clinical researcher were given to Dr May Aung (medical) of the Cook Islands and to Mr Selwyn Hou (nursing/midwifery) of the Solomon Islands. Samoa won the cultural performance award.

The feedback from those who attended the conference was overwhelmingly positive. The PSRH Executive Committee is looking forward to building on these successes in collaboration with partners, such as RANZCOG and ICM, to increase the professional standards of our reproductive Pacific workforce and the quality of care given to women and their families.



Attendees of the PSRH 10th Biennial conference, which was held in Apia, Samoa in July.

College Statements Update

July 2013

A/Prof Stephen Robson
FRANZCOG
Chair, Women's Health
Committee

The Women's Health Committee (WHC) reviewed the following statements in July 2013, which were subsequently endorsed by Council. College statements can be viewed on the College website.

New College Statements

The following new statements were endorsed by RANZCOG Council and Board in July 2013:

- Substance Use in Pregnancy (C-Gen 20)
- Consent and provision of information to patients in New Zealand regarding proposed treatment (C-Gen 2b)

Revised College Statements

The following statements were re-endorsed by RANZCOG Council and Board in July 2013 with significant amendments:

- Progesterone support of the Luteal Phase and Early Pregnancy (C-Obs 29a)
- Management of Hepatitis B in Pregnancy (C-Obs 50) (formerly Hepatitis B)
- Management of Hepatitis C in Pregnancy (C-Obs 51) (formerly Hepatitis C)
- Long term health consequences of PCOS (C-Gyn 26)

The following statements were re-endorsed by RANZCOG Council and Board in July 2013 with minor or no amendments:

- Umbilical Cord Blood Banking (C-Obs 18)
- The use of mifepristone for medical termination of pregnancy (C-Gyn 21)
- Consent and provision of information to patients in Australia regarding proposed treatment (C-Gen 2a)

New College Statements under development

- Management of Gestational Trophoblastic Disease
- Postpartum Bladder Management
- Screening and Management of STIs in Pregnancy
- Generic statement on Evolving Procedures

RANZCOG Women's Health Services

Should you have any queries for the Women's Health Committee or the Women's Health Services department, please use the following phone number: (t) +61 3 9412 2920

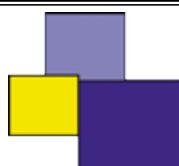
College website

College statements

Can be viewed at: www.ranzcog.edu.au/womens-health/statements-a-guidelines/college-statements.html. Should you have any difficulties with any documents from the webpage, please phone the College (t) +61 3 9412 2920.

Resources for Fellows

This section includes local and international guidelines and articles of interest such as links to new titles on ACOG Committee Opinions and Practice Bulletins, SOGC Clinical Guidelines, National Institute of Clinical Excellence (NICE) guidelines and Department of Health and Ageing reports. Access at: www.ranzcog.edu.au/members-services/fellows/resources-for-fellows.html.



The Royal Australian and New Zealand College of Obstetricians and Gynaecologists *EXPERT WITNESS REGISTER*



Are you interested in joining the RANZCOG Expert Witness Register? Do you have the capacity to give expert medical opinion in the field of obstetrics, gynaecology or a subspecialty? Expert witnesses must have reasonable practice, scientific data and three years of practice in any of the following:

- General obstetrics
- General gynaecology
- Gynaecological oncology
- Obstetric and gynaecological ultrasound
- Reproductive endocrinology and infertility
- Maternal fetal medicine
- Urogynaecology

If so, you may like to consider joining our register.

Please visit www.ranzcog.edu.au/the-ranzcog/expert-witness-register.html for further information.

Farewell to La Trobe Street

Ros Winspear
Archivist

On Wednesday 12 June 2013, the RANZCOG Victorian Regional Committee held an historic and final farewell to Old College House at 8 La Trobe Street, Melbourne.

Bree Morison
Support Officer, VRC

The function was to commemorate the long-standing association of the College, through its various stages, with the building. La Trobe Street was home to, firstly, the Australian Regional Council (ARC) of the Royal College of Obstetricians and Gynaecology, followed by the Royal Australian College of Obstetricians and Gynaecologists (RACOG) and then, in particular, the Victorian State/Regional Committee of RACOG and later RANZCOG that shared the building with the Royal Society of Victoria (RSV) until late 2012. As the first headquarters of the College in Australia and the home of the Victorian State Committee (VSC), 8 La Trobe Street held fond memories for many Fellows. Guests included Fellows, friends and College staff. The function provided an opportunity for guests

to socialise and reminisce in the historic Burke and Wills room (formerly the Supper Room).

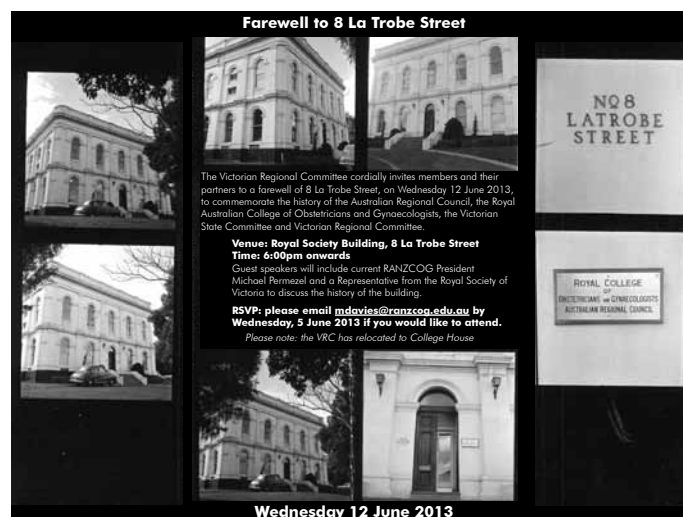
Highlights were the speeches capturing the wonderful recollections and history of 8 La Trobe Street. Dr Alison Fung, Chair, VRC, welcomed guests. Dr William Birch, President, RSV, spoke of the long-standing relationship between the Society and RANZCOG, and expressed a desire to continue this relationship into the future. Dr Jillian de Araugo, Executive Officer, RSV, referred to the historical connection of the building with the Burke and Wills expedition. Current VRC member, Dr Graeme Dennerstein, reflected on the many and varied College activities held over the years. Former VSC Chair,



From L-R: Dr Geoffrey Bishop, former Chairman of the VSC, Dr Gytha Betharas and A/Prof Robert Rome.



From L-R: Dr Peter Ashton, Dr David Abell and Dr Ruben Wein.



Past and present: (L) the original invitation for the dedication of the Arthur Wilson Wing and (R) the invitation for the farewell to La Trobe Street.



The College has had a rich history with the building at La Trobe Street, which was celebrated at the function.

Dr Michael Rasmussen, gave a fascinating insight into the history and events that led to the sharing of the building with the RSV for almost 60 years. Dr Gytha Betheras spoke of the many happy times she and her late husband, Dr Rex Betheras, had spent at 8 La Trobe Street. RANZCOG President Prof Michael Permezel closed the formal proceedings and thanked everyone for coming.

Background history

The events leading to the acquisition of the College headquarters at 8 La Trobe Street began following the formation of the RCOG ARC, in 1947. The first meeting of the Council was held in Sydney on 27 February 1947, and for the next seven years Council meetings were held in various places. The ARC was keen to acquire a permanent headquarters and began a search for suitable accommodation. The catalyst was provided in 1948, on the death of prominent Melbourne obstetrician Dr Arthur Wilson. His colleagues wished to conduct a public appeal to raise money to perpetuate his name. The Arthur Wilson Memorial Foundation (AWMF) Appeal was launched in 1951 by a committee who raised £10 000. It was agreed to use the funds to provide a headquarters for the ARC in Australia. The Royal Society of Victoria (RSV) was approached with a proposal to extend their building at a cost of £20 000. The proposal was accepted with an understanding that the AWMF would

sublet to the ARC. The building would be shared by the RSV and AWMF for 33 years for minor rent. The College headquarters at 8 La Trobe Street was officially opened on 26 August 1954.

Victorian State Committee

Following the establishment of the ARC in 1947, the State Committees were formed. The Victorian State Committee held its first meeting on 6 June 1947, in Melbourne, with Dr John Green elected Chair. Soon afterwards Dr Green left for overseas and Dr Leslie Gleadell became Acting Chair. However, Dr Gleadell assumed the role of Chair with the untimely death of Dr Green in 1948. Dr Green was greatly admired and respected by his colleagues and patients and the John Green Room was later named in his memory. With the College headquarters based in Melbourne, the Committee became very active organising clinical meetings, greeting visiting guests, holding late afternoon 'at homes' and special buffet dinners following quarterly clinical meetings. These activities were well attended and proved popular with the Fellows. When MRCOG examinations began to be held in Australia, training courses were instituted and free lectures provided by Fellows and members. During the mid-1970s, when moves were afoot to establish an Australian College, the State Committees became increasingly involved in the processes that followed. In 1977, Dr

Geoffrey Bishop, Chairman, VSC, led the total re-organisation of the Victorian chapter.

RACOG and RANZCOG

The Australian College of Obstetricians and Gynaecologists was formally established in 1978, the 'Royal' prefix being acquired in 1981. That same year, the RACOG purchased 254 Albert Street, East Melbourne, as a future headquarters. The College moved into the new building in 1983, following substantial renovations. The office of the VSC of RACOG and the VRC of RANZCOG continued to operate at 8 La Trobe Street until October 2012, when it relocated to 254 Albert Street. The final lease expired on 30 June 2013.

The current Chair and Members of the VRC wish to sincerely thank all past Chairs and Committee members for their significant service to the State/Regional Committee over many years. The generous amount of time and expertise that they have dedicated to the Committee is very much appreciated.

Further reading

Super Ardua: The Royal College of Obstetricians and Gynaecologists in Australia, 1929–79, by Ian McDonald, Ian Cope and Frank Forster, Melbourne: RCOG, 1981.

THE ROYAL AUSTRALIAN COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS		
VICTORIAN STATE COMMITTEE CHAIRMAN		
1947 J.F. GREEN	ARC, RCOG	2000 E.M. WHITE
1948 L.W. GLEADELL		2002 H.L. VOLLENHOVEN
1950 E.L. WHITE		2004 P.M. MOORE
1956 W.M. LEMMON		2006 L.H. KOHNMAN
1962 D.F. LAWSON		2007 G.T. EDWARDS
1965 J.K. GABRIEL		2008 R.J. KASHYAP
1968 W.L. SLOSS	AC, RCOG	2010 E.M. UREN
1971 A.H. LONG		2012 A.M. FUNG
1974 K.B. LAYTON		
1977 G.J. BISHOP		
1981 P.S. ALLEN	RACOG	
1983 R.J. PEPPERELL		
1985 D.A. ABELL		
1987 R.M. HOME		
1989 A.J. CAMPBELL		
1991 C.G. TIPPETT		
1993 G.T. KOVACS		
1995 M.E. O'CONNOR		
1996 J.A. HEGAN		
1998 M.J. RASMUSSEN	RANZCOG	

The Victorian State/Regional Committee honour board has now been moved to its new home at College House in Albert Street, East Melbourne.



The evening was very well attended, with guests enjoying the talks and sharing their memories with Dr Alison Fung, second from right, the current Chair of the VRC.



Dr David Abell and Dr Jillian de Araujo at the farewell to Old College House at 8 La Trobe Street.



During the evening, attendees were asked to sign the book and record their memories of the building.

Staff news

New appointments



Latesha Houston started with the College as an examinations administrator for DRANZCOG and MRANZCOG oral examinations in May. Before this she was a student advisor and admission coordinator at the University of Melbourne.

Latesha is a qualified personal trainer and holds a bachelor degree in human movement.



Kate Hutchinson joined the New South Wales Regional Office as the administrative assistant for events, education and training in June. She brings to the role, previous experience gained working in human resources for ITV Media, in the UK.

She was studying at Manchester Metropolitan University working towards her CIPD before she got offered the opportunity to emigrate to Sydney.

Queen's Birthday Honours

The College congratulates the following Fellows on their awards.

Officer (AO) in the General Division

- A/Prof John Clark McBain, Armadale, Victoria
'For distinguished service to reproductive medicine as a gynaecologist, particularly in the area of infertility, to medical education as an academic, and to professional organisations.'
- Prof Robert John Norman, Tranmere, SA
For distinguished service to medicine in the field of reproductive health through significant contributions as a researcher and clinician.

Member (AM) in the General Division

- Winthrop Prof John Phillipps Newnham, University of Western Australia
'For significant service to medicine in the field of obstetrics.'
- Prof Euan Morrison Wallace, Sandringham, Victoria
'For significant service to medicine, particularly in the areas of obstetrics and gynaecology.'

Departure

Viki Talevska, finance officer, left the College in August after seven years at RANZCOG. We wish her all the best for the future and her new career.

Medical pamphlets

RANZCOG members who require medical pamphlets for patients can order them through:
Mi-tec Medical Publishing
PO Box 24
Camberwell Vic 3124
ph: +61 3 9888 6262
fax: +61 3 9888 6465
Or email your order to: orders@mitec.com.au

You can also download the order form from the RANZCOG website: www.ranzcog.edu.au.

Have you changed your address or email account recently?

Have you notified the College of these changes?

If not, please update your contact details via the RANZCOG website (www.ranzcog.edu.au) and follow the link to 'Update contact details' or call 03 9417 1699 to notify the College of your changed contact details.



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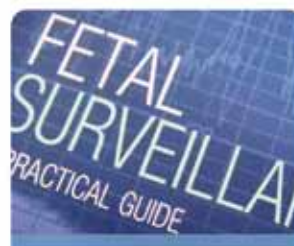
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Are you registered on the RANZCOG website under our 'locate an obstetrician/gynaecologist' link?

Can your colleagues locate you for referral purposes?

On the College website, two 'Register of Fellows' are published: a publicly accessible register of active Fellows in Australia and New Zealand and a restricted access register of all College members.

The PUBLICLY ACCESSIBLE 'Register of Active Fellows' lists your work address, phone number and brief practice details (for example, private and/or public obstetrics and gynaecology or area of subspecialty).

The RESTRICTED ACCESS 'Membership Register' lists the work contact details of members of the College who wish to be included and is accessible only by members of the College who have a website user name and password.

If you would like your work contact details to be included on either or both of the registers and/or would like to update your details already listed on the website, please contact:

Tracey Wheeler
(t) +61 3 9417 1699
(e) reception@ranzcof.edu.au

Obituaries

David Henry Eizenberg
1943 – 2012

David Eizenberg will be remembered by his colleagues as the consummate calm, thoughtful and highly professional obstetrician and gynaecologist, strongly committed in any way he could to collegiate and College activities.

David was born on 29 September 1943. After attending Rose Bay Public and Sydney High Schools, he was a Foundation Graduate of the University of New South Wales (UNSW) in 1966. After three years as resident medical officer, senior resident medical officer and surgical registrar at Prince Henry and Prince of Wales Hospitals, his first three years of specialty training were at Royal Hospital for Women in Paddington. Two years as registrar at the Royal Victoria Hospital, Bournemouth, UK, were followed by a senior registrar year at St George's Hospital, London. In 1973, he obtained his MRCOG, and was later elevated to the Fellowship of the Royal College of Obstetricians and Gynaecologists (RCOG) in 1988.

David had long-term appointments at the Royal Hospital for Women in Paddington and Randwick, St Margaret's, Mater, St Vincent's and Prince of Wales Private Hospitals. He was Secretary then Chair of the Medical Staff Council at St Margaret's Hospital and Secretary of the Department of Gynaecology at St Vincent's Private, both for ten-year periods. He had long terms as an examiner for the College Diploma and Membership examinations. He was a clinical lecturer for UNSW at St Margaret's Hospital. In 1979, he became a Foundation Fellow of the Royal Australian College of Obstetricians and Gynaecologists.

An extremely keen exponent and teacher of vaginal surgery, his other long-term clinical interest was infertility. He was foundation director of the Infertility clinic at the Royal Victoria Hospital in Bournemouth (1973–74) and Director of the Infertility Clinic at St Margaret's Hospital (1979–93). Of high obstetric significance, in 1976, he introduced partograms to St Margaret's Hospital in the management of labour, a concept later taken up by all obstetric units in NSW. His later interests were in gynaecological endosurgery and endometriosis. He has contributed 12 papers to the academic literature and has given numerous lectures during his career.

David passed away on 14 July 2012. It would be most difficult to find a colleague or patient who would not have spoken of David with anything but the highest respect and regard of his knowledge, skills and kindly, helpful and considerate manner.

A/Prof Bernard Haylen
FRANZCOG
NSW

Dr Satish Prasad
1963 – 2012

Satish Prasad was born on the 26 July 1963, the youngest of nine children. His father was a sugar cane farmer in the town of Lautoka, Fiji. Given the circumstances and the financial situation at that time in Fiji, it is a true inspiration that he completed his primary and secondary schooling years to eventually enrol in the medical program at the Fiji School of Medicine. He graduated from the University of the South Pacific in 1989, and obtained the RACOG Diploma in Obstetrics in 1994. In 2002, he completed the training requirements to become a Fellow of RANZCOG.

In 2003, Satish decided to settle down with his family in Rockhampton in Central Queensland, where he worked at the Mater and Hillcrest Private Hospitals. His progress from beginning in a small town in Fiji to becoming a specialist in obstetrics and gynaecology is an inspiration to all, especially his children.

Satish was a pioneer as well as a caring doctor, a wonderful teacher and mentor. He will forever be remembered for his humour and storytelling. He was extremely thoughtful and cared greatly for everyone he knew. He was passionate about making a difference in the lives of his patients. He always wanted to be prepared for the future and urged friends and colleagues to have life insurance and income protection.

An avid reader and film buff, Satish also enjoyed golf and tennis. He loved travel and spent 2012 travelling widely, attending conferences and doing volunteer work in Fiji and India. Above all, Satish was a man who truly loved life and the people who shared it with him.

Satish passed away on 23 August 2012, at the age of 49 years. He had been diagnosed with stomach cancer in 2010 and was slowly getting back into clinical practice in 2012 when he died suddenly and peacefully in his sleep. His untimely death has saddened his family, friends, patients and the community. He is survived by his wife Angela, a son and daughter. His son Avicheel is studying medicine at the University of Queensland.

Dr Fatima Ashrafi
FRANZCOG
Queensland

RANZCOG RESEARCH FOUNDATION



Membership of the Foundation

Membership of the RANZCOG Research Foundation is open to all members of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists and to all others with an interest in the aims and objectives of the Foundation.

By joining the RANZCOG Research Foundation you are directly contributing to the internationally recognised research conducted in Australia and New Zealand.

Membership of the RANZCOG Research Foundation is free to all RANZCOG Fellows residing in Australia or New Zealand. Fellows wishing to accept membership of the Foundation should advise the RANZCOG Research Foundation Coordinator in writing.

RANZCOG trainees, clinical researchers and other interested individuals are warmly welcomed. Membership fees are tax deductible.



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All donations are tax deductible.

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Supporting Research

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The RANZCOG Research Foundation works closely with the RANZCOG Board, Council and College Committees to further the needs for research and research training in the broad fields of obstetrics, gynaecology, women's health and the reproductive sciences.



Our Scholars

The Foundation proudly supports promising young Fellows, clinical researchers and scientists undertaking high quality, innovative research and research training at an early stage in their career.

Scholars supported by the RANZCOG Research Foundation have a strong record of subsequent achievement in research and in academic careers in Australia and overseas.

Grants and Scholarships



Each year, approximately \$120,000 is disbursed helping to support early career researchers in their work.

The Foundation continues to expand its program of grants, scholarships and other awards. Recent initiatives include Collaborative Bachelor of Medical Science Research Scholarships, Project Grants to assist RANZCOG trainees in undertaking their research project and the *Mary Elizabeth Courier Research Scholarship*, introduced following a bequest to the Foundation by her late husband, Australian lithographic artist, Jack Courier.

Further Information

Further information about the work of the Foundation is available on the website at: www.ranzcog.edu.au/research



Any questions should be directed to the RANZCOG Research Foundation Coordinator:

Ms Georgina Anderson:

t: +61 3 9417 1699

e: ganderson@ranzcog.edu.au

I give the RANZCOG Research Foundation permission to publish my name as a donor to the Foundation in any College publications. ☐ Yes ☐ No

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