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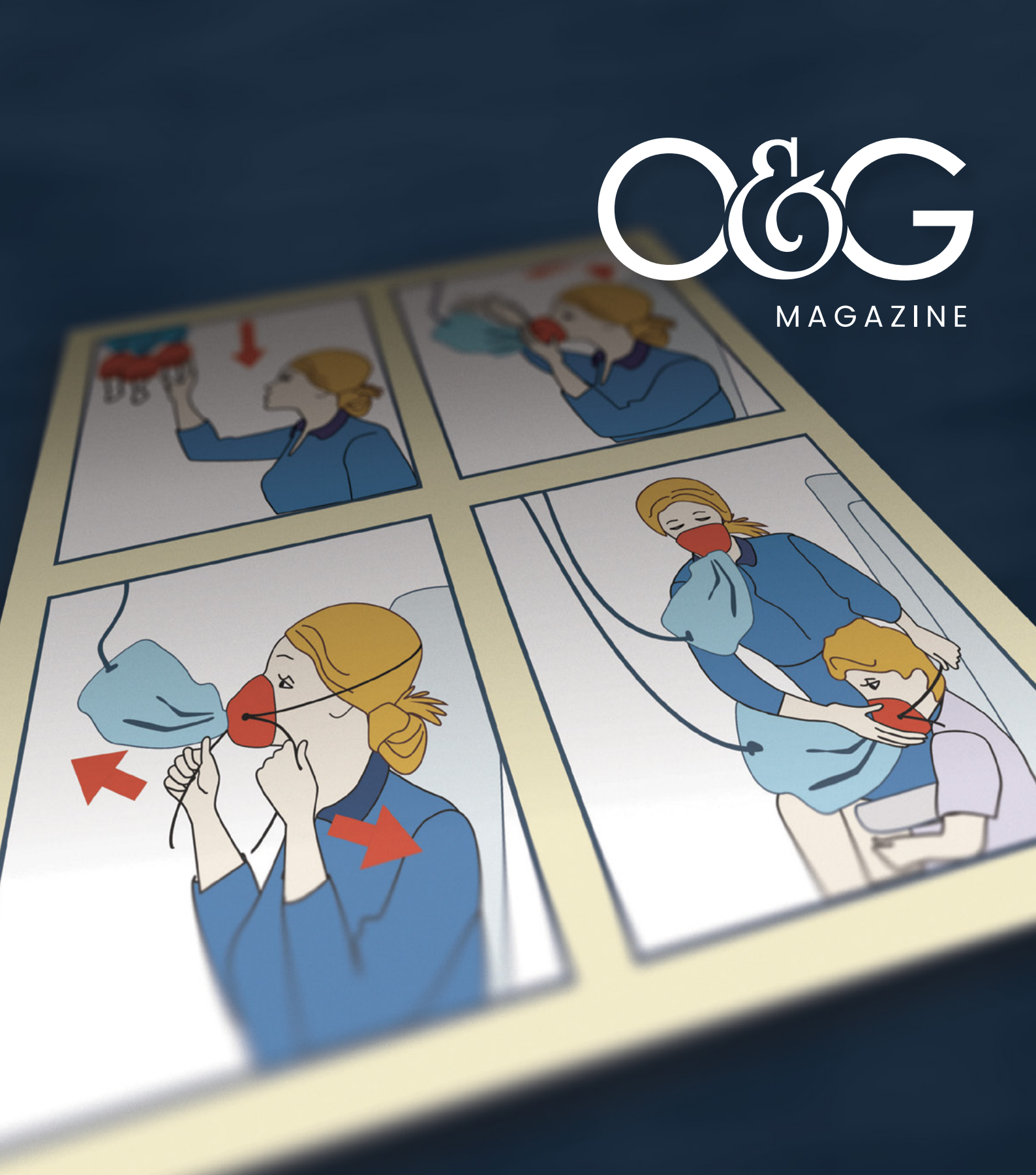

SELF-CARE

Vol. 22 No. 2 | Winter 2020
a **RANZCOG** publication

O&G MAGAZINE

Vol. 22 No. 2 Winter 2020

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O&G Magazine authorised by Ms Vase Jovanoska

ISSN 1442-5319

Cover image ©Helen Bony

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Self-care

Women's health

The College

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From the President

Dr Vijay Roach
President

The *O&G Magazine* Advisory Group must have had a premonition when they chose Self-Care for the Winter issue of the publication. How could they have predicted a global pandemic and the dramatic impact on health, healthcare, healthcare workers and the community? Beyond physical illness and death, the world is grappling with the economic effects that hurt now, but will last long into the future. The social and psychological distress is real and significant. We have witnessed the terrible suffering of populations across the world. Though Australia and New Zealand have not been spared death and disease, swift action to close borders, strict social distancing (an unfortunate term) and virtual lockdown appear to have been effective in flattening the curve. What lies ahead is uncertain, and nothing provokes anxiety better than uncertainty.

The need for self-care in the pandemic is perhaps self-evident, but it's not a practice that healthcare workers, doctors, nurses or midwives do well. Patient first, family second, self last. Our vocation is to care for others and that is important and valuable. But when we forget ourselves there are consequences, for those for whom we care, for our families and for our personal wellbeing. It's important to call it out. It's important to remind the caring professions that self-care isn't weakness or inadequacy. In fact, it's a right and a responsibility. The expectations that we apply to patient care must also apply to ourselves.

In this issue, our authors cover both physical and mental health, the experience of our trainees, career progression and professional stages, the impact of adverse outcomes, disciplinary and legal processes and the different settings in which our members work – rural, remote and metropolitan. There's information on the College's support for the wellbeing of trainees and all members. We are pleased to welcome the aptly named Clare Wells, RANZCOG Wellbeing Coordinator, to the College who will work alongside Carly Morefield in the Training Services Unit.

Former US President, John F Kennedy, is quoted as saying 'The Chinese use two brush strokes to write the word 'crisis'. One brush stroke stands for danger; the other for opportunity. In a crisis, be aware of the danger – but recognize the opportunity.' The COVID-19 pandemic had the potential to destabilise the College. Instead, I think that we can be justifiably proud of our response. The President, Board and Council have worked with the CEO and staff in a collaborative manner with a unified purpose. College House was closed and all staff, in both Australia and New Zealand, were working at home within three days. Council week was run entirely through virtual meetings. We continue to work from home, covering issues related to the pandemic and business as usual through (yet another!) Zoom meeting.

RANZCOG was the first College to issue specific guidance, first on pregnancy, then surgery, pregnant healthcare workers, telehealth, PPE, Māori, Aboriginal and Torres Strait Islander health, and many more. We made sure that our message was consistent across both countries. We chose to give high-level, evidence-based advice and acknowledged that local circumstances would determine regional responses. RANZCOG became the leading voice in women's health in Australia and New Zealand. Our message on pregnancy has been translated into several languages and weekly videos from Board member, Dr Gillian Gibson and Senior Australian of the Year, Prof John Newnham, have kept our members, and the general public, reassured and informed.

The disruption for our members has been significant. Those in private practice have seen their incomes slashed while their expenses still continue. We have had to care for anxious and disenfranchised patients. For trainees, the cost is very high. Deferment of exams and assessments, changes in rotations and the abrupt cessation of elective surgery will all impact training. Rather than deny that fact, the College has actively engaged with trainees to explore innovative approaches to allow them to progress through their training. The trainees themselves have displayed amazing equanimity, a testament to their character and commitment.

What lies ahead will be challenging and difficult. Our College, your College, has taken its place as the leader in women's health in Australia and New Zealand. We've achieved this together. I want to express my deep and sincere gratitude to all of you, my colleagues, my friends, the RANZCOG family. I'm looking forward to seeing you, in person, on the other side.

From the CEO

Vase Jovanoska
Chief Executive Officer

When I wrote my last CEO Report for *O&G Magazine*, I had no idea what was coming. At the time, we were experiencing the worst bushfires that Australia had witnessed and unbeknownst to us all, another great threat was looming – COVID-19. A term that will be synonymous with the year 2020.

The world is feeling the effects of a global pandemic where hundreds of thousands of lives have been lost and many people have been infected. The race to curb the spread of the virus continues and in Australia and New Zealand, we have done our best to flatten the curve with hope to return to life as we knew it before we became isolated from each other.

Through the adversity that COVID-19 has brought, I am proud of how RANZCOG has responded to the situation. We were proactive in implementing a full working-from-home arrangement for staff across Australia and New Zealand, quick to adopt videoconferencing facilities to run meetings and social media tools to stay connected to each other and notably, for the first time, we ran College Council Week entirely via videoconference. All credit must go to the quick decision-making of the RANZCOG Board and President Dr Vijay Roach as well as the swift and seamless implementation of technology and new ways of working by College staff across Australian and New Zealand.

I suppose it is somewhat fortuitous that this issue of *O&G Magazine* is about self-care. Never has self-care been so important, and the College is committed to ensuring that our members, trainees and staff are taking care of their health and wellbeing during this challenging time.

By now, you will be aware of, or affected by, the cancellation or postponement of many major College events, workshops, exams and activities. This was a necessary action on our part in stopping the potential spread of COVID-19. Our members and trainees are crucial to the health of our nation and it is therefore also our responsibility to do our part to ensure our healthcare services are not overwhelmed.

Our natural instincts are to help others before we do anything for ourselves; however, sometimes we need to remember that we must take care of ourselves first, to be able to help others. It is like on a flight when you must put your mask on before assisting someone else. Right now, you must look after your health first, the health of your loved ones and, through your duty as medical professionals, the health of our country.

Over the past few weeks, the President and I have had the pleasure of meeting (via Zoom) with members and trainees across Australian states and territories and New Zealand, to receive your feedback, hear your experiences and understand the challenges you face. It has been insightful and valuable, and I am grateful to those who have taken the time to attend these meetings and provide input.

The College is here to support you during this time and I would like to hear from you, so please contact me at ceo@ranzcog.edu.au. You can also contact our Training Support Unit (TSU) at traineeliaison@ranzcog.edu.au and +61 8 6102 2096 or our Health and Wellbeing Coordinator at cwells@ranzcog.edu.au and +61 3 9114 3939.

If you would prefer to speak with someone externally, Converge International (specialists in psychology, mental health and wellbeing) are available on 1300 687 327 (Australia), 0800 666 367 (New Zealand) or, from other countries on +613 8620 5300.

RANZCOG's Information Hub https://ranzcog.edu.au/covid19 has continued to be a valuable source of information for our members, trainees, stakeholders and the public over the last few months. I would also like to encourage you to send your personal stories and experiences to the College for feature in Connect. This is a great way to engage and stay connected with the wider RANZCOG community.

I would like to finish by thanking you all for continuing to contribute to making RANZCOG the leading voice in Women's Health across Australia and New Zealand. Our members, trainees and College staff are all committed and united each day (even during a global pandemic), in the pursuit of the best outcomes and the best healthcare for women and their babies.

Stay safe and take care.

LEADERS IN FOCUS

Dr Nisha Khot
MBBS, MD, FRCOG, AFRACMA, FRANZCOG

This feature sees Dr Nisha Khot in conversation with RANZCOG members in a broad range of leadership positions. We hope you find this an interesting and inspiring read.

Join the conversation on Twitter
#CelebratingLeadership @RANZCOG @Nishaobgyn

Dr Paul Howat
FRANZCOG

For those who don't know Dr Paul Howat, this interview will hopefully be the perfect introduction to the Chair of the newly formed Wellbeing Committee at RANZCOG. It seems only appropriate, given the theme for this issue is Self-care. This Committee will aim to address the issues that have a huge impact on all of us at different stages in our career.

What does a typical day look like for you?
My typical day has changed quite a bit since the pandemic. These days it often starts off as 'work from home' checking emails and dominated by all things COVID-related. The positive side to this is that I have rapidly upskilled in the use of technology and learnt new skills. We had our first Mortality and Morbidity meeting via Zoom last month. I was pleasantly surprised that the attendance was better than when we had the meetings in person.

One thing that hasn't changed despite this new way of life is my evening walk with Sibyl, our Soft-coated Wheaten Terrier.

What prompted you to choose O&G?
I really enjoyed O&G as a medical student. I will give credit for this to my exceptional teachers at Melbourne University who not only taught the subject well but also took a keen interest in their students. My love for O&G only grew once I started my training at Mercy Hospital. I liked the combination of medicine and surgery. I was always made to feel welcome in the specialty as a student. Our current students rank O&G as their best taught and most enjoyable subject at my university. This reflects the same passion I experienced all those years ago.

What advice would you give specifically to male medical students and interns wanting to pursue a career in O&G?
My advice would be the same regardless of gender. If you are interested in O&G and you care about women's health, don't let your gender be a barrier to choosing a career in O&G. You will not be made to feel unwelcome and your seniors will by and large support you. I acknowledge that every male doctor will encounter some patients who will not want to be cared for by them. Respect the decision that these women make and remember that there are always solutions.

I encourage medical students and interns to get involved in advocacy in the simplest ways possible. Teaching boys and young men how to interact respectfully with women is something that can have a huge impact on women's health and wellbeing. Ultimately, this belief in equity for all should underpin any career decision and especially one in women's health.

What roles have you had within RANZCOG? What did you achieve and what did you learn?
I was on the RANZCOG State Committee for Queensland when I worked in Cairns. I was a member of the Queensland State Committee for eight years and Chair for four. I was encouraged by my senior colleagues to take on this role and I benefited from the experience of regularly interacting with the College, the Department of Health and the relevant ministers at the time. I was able to highlight indigenous health issues within the state as well as be a voice outside the state capital.

My proudest achievement was the setting up of an exam preparation course in Queensland where none had existed before. This was especially valuable for local trainees who prior to this would travel to Sydney or Melbourne to attend a course. I ran the course myself for three years before handing over the reins. I am happy that it is still going strong with good attendance numbers.

What leadership roles have you held and what advice would you give to aspiring leaders?
I was the Director of Women's Health Services in Cairns for many years. I am currently the Divisional Director of Women's and Children's Health Service at Northern Hospital in Victoria.

I believe that, as doctors, we are all leaders. At the most basic level, a doctor is the leader of their team. This may be a team in theatre performing surgery

Pumpkin scones

My grandmother taught me to make scones. The key is to have the lightest touch to bring all the ingredients together, and don't overwork the dough. Pumpkin scones are associated with Queensland and are sometimes mocked, but they look and taste great, are an excellent way of using up pumpkins and they celebrate the 20 years I spent in that great state.

Ingredients

250g pumpkin
300g self-raising flour
Pinch of salt
20g butter
1 egg

Method

- The pumpkin needs to be cooked – if you steam it or boil it, it becomes very wet. Steaming is probably better, or you could bake it in the oven – even better.
- Puree the pumpkin – I like to push it through a strainer to remove any fibrous bits.
- Sift the flour and salt and rub in the butter and pumpkin puree with your fingers.
- Add the beaten egg to make a soft dough – don't overmix it.
- Add a little bit of milk if it is too stiff.
- Put it on a floured surface and gently pat down to about 3cm thickness.
- Cut into wedges with a floured knife – sharp downward push.
- Brush with milk and bake for 15–20 minutes at 200°C.
- These scones cry out for butter. They don't taste right with other spreads, so if you don't eat butter I'd suggest just enjoying them on their own.

or a team looking after women in labour. The ability to communicate clearly and succinctly is crucial to effective leadership. Always put your patient first when making any decision. Accept feedback from every team member because this will help you hone your leadership style. As you gain experience, put yourself forward for positions that bring more responsibilities. And remember to nurture leadership in those around you. One of the most important roles of a leader is to have a succession plan in place. My own experience of encouraging my trainees in Cairns to take on further responsibilities meant that when I left, I handed the running of the department to very capable colleagues – a fine team of committed and remarkable women.

What are your future plans?

As I get closer to retirement, I am rethinking my priorities. I started a Masters of Surgical Education through RACS and am planning a sabbatical to further my knowledge and experience in education. I want to design a low-cost, realistic simulation-based model to teach vaginal surgery including vaginal hysterectomy. I am also interested in exploring the effects of surgical error on the surgeon, their wellbeing and their career. After I turn 60, I really only see myself working one to two days a week in areas I find stimulating and challenging.

In addition, I want to explore the non-medical world. A career in medicine can mean our younger, early interests fall away due to the narrow focus of our careers. A busy clinical life leaves very little time and opportunity for other pastimes. I have many happy memories of childhood camping trips. Travel may look very different in the future. I loved camping away for weeks on end as a child and I'd love to do that again and explore our wonderful country with Mark and Sibyl, and go to places we've never been. It will also be a good way to catch up with friends across Australia. I enjoy cooking and am starting to grow my own food too. I am looking forward to a simpler life.

How do you look after yourself as well as your trainees and colleagues?

I got a bit of a wake-up call recently and this has prompted me to take my own health seriously. I enjoy walking and last year, Mark and I walked 320km across the UK from one coast to the other. We knew it would be tough and we trained for it by going on long walks locally. The sense of achievement at the end of the walk was so special that we vowed to do many more walks.

Trainee wellbeing and the wellbeing of Fellows and Diplomates is something I have always been passionate about. I am very happy to see that this is something the College is addressing proactively. I hope the Wellbeing Committee that has been set up will tackle bad behaviour and bullying at all levels. 'Operate with Respect' should be the basis for all professional interactions, whether they be between peers or with trainees.

What message do you have for your younger self?

- Be kind to yourself. You have no reason to be ashamed of who you are.
- Be forgiving of others. You don't know what they are dealing with in their life.
- Above all, make time for yourself, for the things you love and for the people you love.

If you have not yet read it, I recommend you read Paul's Letter to get to know more about his life and career. www.ogmagazine.org.au/21/1-21/lgbtqia-personal-experience/

Those who know Paul will also be familiar with his cooking skills. Since many of us are honing our cooking and baking skills while in COVID-19 restrictions, Paul has very kindly shared his recipe for pumpkin scones.

If you would like to nominate someone to be featured in Leaders in Focus – someone who has been a mentor to you and would be of interest to the wider O&G community – please let me know.

You can send your nomination to Sarah at RANZCOG, sortenzio@ranzcog.edu.au.

– Dr Nisha Khot

Editorial

Dr Jenny Dowd
B Med Sci, MD, FRANZCOG
Royal Women's Hospital, Melbourne
Women's Obstetric and Gynaecology Specialists

Little did we know when the idea of Self-care was suggested as a theme for *O&G Magazine,* that we would be compiling the articles in a time of self quarantine, social distancing and drastically reduced routine medical services due to an international health crisis! One definition of self care is 'the practice of taking an active role in protecting one's own wellbeing and happiness, particularly in times of stress,' and this seems particularly appropriate right now.

As I write this, we seem to be over the first wave of COVID-19 panic. The curve is flattening, and there is talk about relaxing restrictions and even potential local eradication of the virus in Australia and New Zealand. Hopefully with early trials of treatments and multiple centres developing a vaccine, we will not face a global 'relapse' and many of those newly acquired ventilators will stay wrapped in plastic.

One noticeable effect of the current pandemic is learning how we as a society, and as individuals, deal with such widespread disruption to routine life and work. The media have been full of ways to maintain sanity while either working (and often schooling) from home, working and placing oneself at risk, or dealing with unemployment or loss of business income. As health professionals, we are lauded for being on the frontline, particularly in obstetrics as this is one area that can't be put on hold. In our speciality of O&G, we are often confronted with changing situations requiring urgent decisions, but usually still within our sphere of influence and expertise. Now we have had to face the possibility of a potentially personally risky working environment on top of the usual uncertainties of our daily clinical lives. Health workers are on the frontline of exposure and we know that many of us may get the virus (and hopefully recover) but in the meantime may put our families or other contacts at risk.

The way we respond to such stress says something about our innate personalities: is the glass half full, half empty or just at 50%? Do we respond with anxiety and become overcautious, or play down the risk and cut corners with a degree of fatalism? Coping with post-Covid life will be played out on the background of all the other stressors innate in our profession.

Doctor's are known for neglecting their own physical health and are notorious for ignoring mental health issues. This was examined two years ago in our *O&G Magazine* issue on 'Mind Matters' (Spring 2018). Specialists in particular are not good at having their own GP. Suicide is the leading cause of death for men aged 15–44, and female doctors kill themselves at three times the rate of other employed women. For every death by this cause, there are thirty attempts. This has been publicly discussed following our Past President's telling of his own story as an at-risk young doctor and how friends at the time intervened to offer salvation. (https://insightplus.mja.com.au/2018/41/learn-from-me-speak-out-seek-help-get-treatment/)

In the recent US Specialists and Burnout Survey 2020, (Medscape.com/slideshow/2020-lifestyle-burnout-6012460), 46% of the 600 O&Gs answered that they felt burnt out. This being described as 'a long-term, unresolvable, job-related stress that leads to exhaustion, cynicism, feelings of detachment from one's job, responsibilities and lack of a sense of personal accomplishment.' Interestingly, each age group highlighted different concerns. Of the total 15,000 specialists, the Gen X's (age 40–54) were most burnt out. Forty-eight percent described themselves as suffering this with their main issue being lack of respect. These doctors are also in the band of the 'sandwich generation', who are mid-career, at their busiest professionally and often juggling multiple roles outside work. Of the Boomers (age 55–73), 39% were burnt out and were most frustrated with computerisation, and of the Millennials (age 25–39), 38% were already burnt out due to too many hours at work.

There is a risk of confusing burnout with major depression, and as doctors we are taught not to show emotion or ask for help. We may end up suffering from compassion fatigue and seeing patients as a chore. As an obstetrician, I still get a buzz from delivering a healthy, screaming baby to besotted parents and believe that when I lose that feeling, its time to reconsider my priorities.

While we acknowledge these issues at an academic level, many of us will not face them personally or don't know how to raise them with at-risk colleagues. The following articles will hopefully cover a range of practical ideas to help us identify and cope with some of the stresses inherent in our speciality. There are issues specific to certain ages and career stages, practical tips about work practices and organisational strategies, and contacts for resources available within RANZCOG and in other domains. As one of our authors writes, 'It's okay to not be okay'. Not every article will resonate with each reader, but hopefully the information and suggestions described will be available as useful resources when required.

So what can we learn from the current situation? Forced social and workplace changes happening quickly may drive innovation. We may have to evaluate how and why we work, how we manage Self-care, and care of our patients and colleagues. We may become more agile in practice, with Telehealth and Zoom meetings having an ongoing role, and some of us will cope better than others with change and uncertainty.

When looking for a pithy quote to end this piece, I found many somewhat stomach-churning, fluffy ideas about self-love, full of sunsets and kittens. However, the underlying message of many was that we can't look after our patients if we are impaired ourselves. So, in this time of donning and doffing PPE practice, I think we should again look to the airline industry for safety protocols and follow the familiar advice to 'Put your own oxygen mask on first.'

I know to look after myself – I'm a doctor!

Dr Margaret Kay
MBBS(Hons), PhD, FRACGP, DipRACOG, GAICD
Medical Director,
Queensland Doctors' Health Programme

Most physicians deeply value their health. It is a privileged position to walk with patients, helping them manage their health issues. Few doctors would argue that self-care was not important. Many doctors, though, struggle to integrate self-care into their routines. At times of transition (work, family or other life changes) self-care practices can be disrupted. With the focus on the COVID-19 pandemic, doctors' wellbeing has come sharply into focus.

Confronted with an uncertain future, with the health system central to unfolding events, doctors have found themselves personally and professionally challenged to consider their 'framework for self-care'.

It is reasonable to step through some of the emerging concerns for doctors related to COVID-19. On the personal front, doctors worry about the health of their family members. They are concerned that their exposure at work will increase their families' risk. At home, doctors have become the resource for family and friends who seek clarity about what they should be doing. Education of children and care of vulnerable older family members, not to mention increased complexities of shopping, add to the personal issues faced.

In clinical practice, doctors face constant changes:

- Changes to their practice with the introduction of telehealth.
- Changes to their healthcare teams as members are seconded to work elsewhere, while vulnerable staff now work in different roles.
- Apprehension regarding the availability of PPE.
- Clinical care is altered to reduce exposure for both pregnant patients and pregnant doctors.
- Administrative tasks such as updating websites and sourcing clinic supplies are more pressured with extra decisions each day.

COVID-19 has 'unmasked' the substantial intersect between the personal and professional lives of doctors.

Beyond the illness itself, financial concerns require attention as professional and personal investment decisions are reviewed. Many doctors have confronted overt discrimination that adds further burden. These issues impact on wellbeing.

Large volumes of information (clinical information, daily statistics, hospital procedures and government announcements) are absorbed and integrated into changes in personal and clinical routines.

Doctors generally dismiss their personal vulnerabilities related to age and previous illness, but this is no longer possible. Reflection upon personal risk factors while working at the coalface can be confronting. Beyond the risk of infection, doctors are also exposed to their patients' anxieties and their healthcare team's worries. These can magnify personal concerns. While the frustrations related to decisions by healthcare hierarchy may be tolerated, it is more difficult to understand when close colleagues make very different decisions. Differences can be confronting. Feelings inevitably complicate our decisions and responses. Simply normalising feelings of anxiety, guilt, grief and trauma can be helpful.[1] The capacity to think through the multitude of issues can be (frustratingly) slower when there is so much using up our 'bandwidth'.[2] There will be many stages in this marathon that lies before us.[3]

These self-care messages resonate strongly with the self-care messaging that has been a part of the doctors' health education for many decades. Doctors need to address their self-care if they are to deliver quality care to their patients.[4] Physical and mental health are vital aspects of self-care that remain intertwined. It is rare for doctors across the nation and across the specialties to be facing a crisis together as with the COVID-19 pandemic. However, doctors regularly face difficult times; the traumas of a difficult case that can be heart-wrenching, medicolegal issues, personal issues or medical issues. Practicing self-care enables resilience in these situations.

In acknowledging that self-care is important, it is a perfect time to reflect further: What is self-care, and why has the medical profession struggled to engage with self-care?

What is self-care?

Doctors are health literate with more than a basic knowledge of self-care.[5] Clinics are spent providing patients with lifestyle advice on the importance of a healthy diet and exercise while avoiding smoking, illicit drugs and excess alcohol. Lifestyle factors are intimately connected with so many of health issues – contraceptive choices, subfertility, gestational diabetes, endometrial carcinoma. Doctors are reinforcing these self-care messages every day.

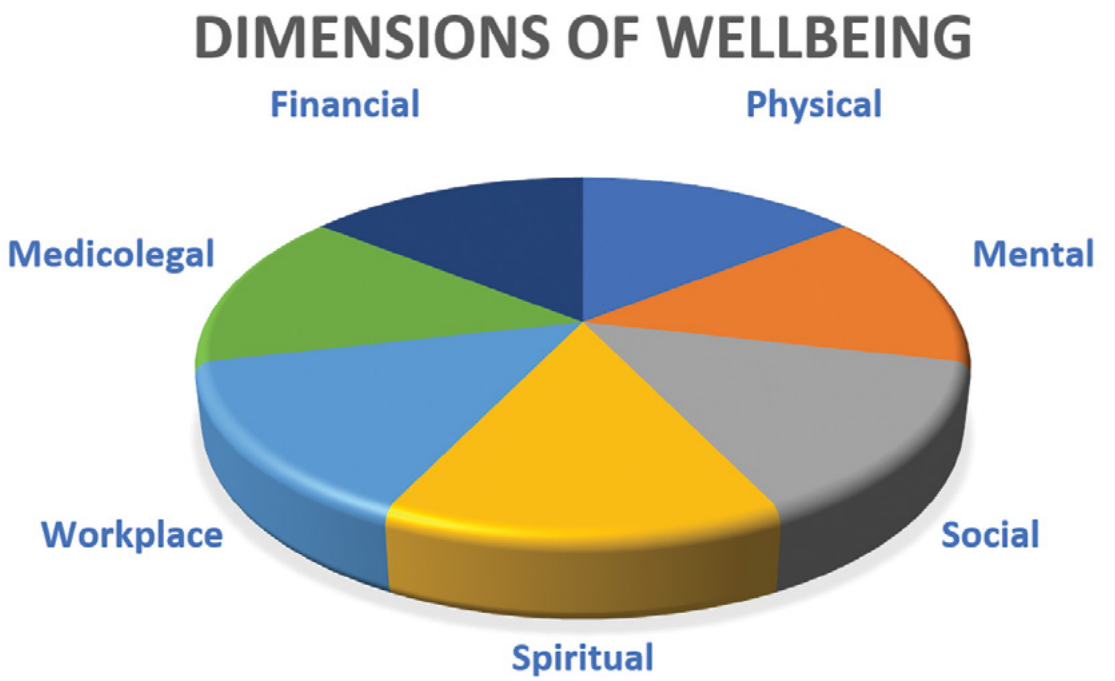

Figure 1. The seven dimensions of wellbeing commonly used for doctors.

Doctors are discerning when scrutinising the lay messages, which include, how to maintain a healthy diet,[6] how much exercise is enough[7] and the importance of adequate sleep.[8] Each of these is inextricably linked to our mental health. Improved diet,[9] exercise[10] and sleep all enhance our mental health. Specific strategies for addressing our mental health go well beyond mindfulness sessions. Having a range of strategies and understanding the purpose of each of these, what works and when these strategies are best applied is key to enabling mental wellbeing. Key digital resources have been curated by ANZCA in the Long Lives, Healthy Workplaces document, including mental wellbeing resources.[11]

A framework of 'dimensions of wellbeing' can assist in reflecting on personal wellbeing. Though these dimensions may vary, seven are commonly used for doctors (Figure 1). While other dimensions such as environmental or emotional may be added or exchanged, such debates distract from the key message that wellbeing is multidimensional. Each of these dimensions need attention. At different times in life, the strategies we use to address one or more dimensions may need to change. Proactive engagement with a framework enables self-reflection to help identify and address problem areas.

Why has the medical profession struggled to engage with self-care?

A lack of knowledge cannot explain why doctors fail to practice self-care themselves. While it is often assumed that disinterest in self-care is simply an attitude adopted when donning the 'mantle of the white coat', the reasons are more complex than simple arrogance. It is useful to explore why the discourse of self-care remains fraught. Firstly, the representations of wellness in the literature rarely gel with the lived experience of medicine. Wheels of wellness (Figure 1) with evenly spaced segments are almost confronting. By making wellbeing look 'easy' and 'neat', such representations contrast starkly with the personal experience of doctors and the lives witnessed when caring for patients. Similarly, the concept of 'work-life balance' can seem unattainable when life and work remain inextricably enmeshed with long hours of work, and the patient remains the immediate priority. This apparent cognitive dissonance makes it easy to conclude that the message does not apply, rather than seek an adaptive solution.

Again, much of the commentary in the doctors' health literature insists that doctors do not look after themselves. Yet, doctors do value their health and there is good evidence that doctors benefit from their health literacy.[12] Few doctors smoke and many find time for physical activity including skiing, bike riding and surfing. Doctors have a relatively low standard mortality rate when compared to the community. It can be difficult to engage with a message that appears to lack authenticity.

Messages of self-care need to be packaged in a way that enables physicians to incorporate such messages into their daily routines, while acknowledging the difficulties that doctors experience. Research demonstrating why self-care is important for doctor and patient can also help. Breaking for lunch improves the physician's cognitive function.[13]

One self-care message is that all doctors should have their own GP. While the number of doctors who say that they have their own GP has increased, many doctors do not attend their GP regularly. Having a relationship with a GP is key to enabling health access, not just 'having a GP'.[13]

Doctors record higher stress responses on surveys but are often very aware of their mental health issues. The key issue is access to care. Health access is complicated by concerns of confidentiality, embarrassment and the impact on training and

future insurance. While doctors should have positive strategies for managing their day-to-day mental health, such strategies can never be enough for every situation. Increasing doctors' understanding of safe pathways to care will help to remove barriers and reduce poor help-seeking behaviours.

Stepping forward, doctors do need to address their personal self-care as individuals; however, self-care is more complex than a checklist or wellbeing framework. It takes engagement to be effective. Enabling doctors to hear the current messages of self-care may help them successfully navigate sustainable, lifelong self-care solutions.

Importantly, there are many systemic barriers that also affect self-care. These barriers exist at the healthcare team level and within the broader health system.[14] Progressing doctors' wellness requires an understanding of how these different levels (individual, team and systems) intersect. Hospitals and colleges need to work together to enable sustainable wellness solutions. Doctors' health can no longer be visualised as an 'add on'. Their wellness is central to patient care.

Compassion is a key element at each of these levels: self-compassion, compassion for peers and compassion fostered within the system.[15] Senior doctors should use their authority and capacity for engagement to enable systemic change.[16] Junior doctors benefit greatly when their seniors support them.[17] Being well-versed in the doctors' health literature helps enable such change.

The current health system disruptors provide an opportunity for doctors' wellness to be effectively integrated into both public and private health systems. Doctors do look after themselves, but we can do much better when we work together.

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Further reading

Queensland Doctors' Health Programme has a series of resources to support doctors during COVID-19. Available from: https://dhasq.org.au/coronavirus-covid-19-information/

Tackling pressure at different career stages

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Tanja: Prevocational O&G trainee

I believe that the majority of us would identify as having a healthy amount of 'performance anxiety'; that feeling of increased vigilance that makes us take that one more step preparing for high-pressure exams or, as I have more recently experienced, college applications.

Having gone through the RANZCOG training application process last year I experienced a new level of pressure that I had not experienced before and my healthy level of 'performance anxiety' felt overwhelming at times and I had to adapt in order to get through.

There are some unique attributes to the application process. On a professional level, it marks developing as a doctor in O&G and learning new skills while committing to additional activities to optimise application requirements.

On a personal level, two features made this process further high pressure. I have wanted to do nothing more in my working life than pursue a career in O&G; there was no plan B. Especially in light of the maximum application attempts, it played on most of our minds: 'this goal may not actually be achievable, and then what?' In addition, the College application co-existed with raising a young family, and while prioritising the application process, other parts of life undoubtedly suffered, leading to a sensation of guilt.

During this process, I learned attributes of self-care that worked for me. I learned that planning ahead and having dialogues with my family about the weeks ahead could optimise sleeping, eating and exercise. I learned to find mentors in more senior colleagues who provided guidance and support. Lastly, during this process, I have engaged in mindfulness sessions facilitated by our department, which have been of great benefit professionally and personally.

Lauren: FRANZCOG trainee

It's taken several years and a good dose of perspective to appreciate the importance of genuine self-care. I commenced training in 2017 and I was filled with enthusiasm and excitement. I'd worked hard to get onto the training program and I was looking forward to the challenges of O&G. I was happy working long hours and I loved being at the hospital, but outside of work, my normal life was starting to fall away.

Fast forward 12 months and I was struggling; exams loomed and the inevitable tragic outcomes had distressed me immensely. I didn't share my anxiety with others, I didn't want to seem weak. My mental health was pretty poor – but it's only in retrospect that I can recognise that. I carried the poor outcomes that had happened at work with me always – like a weight in my chest, panicked that I would miss something and a family would be devastated. The responsibility of our job was a backpack full of bricks I could never take off.

It was only when I shared these feelings – at first quietly with a trusted colleague – that I realised I wasn't alone in feeling this way. I learnt that it was only in sharing my experience that I could move forward from the paralysis of fear-based decisions. Our department hosted a consultant-led session focused on the biggest mistakes they had made in their career. I sat quietly listening to consultants I respected immensely, humbly share mistakes they'd made. These mistakes stayed with these doctors, the emotions heard as their voice caught in the back of their throat. But I learnt in that important session – that none of us are perfect, but we learn from one another and it's in supporting each other that we care for one another.

Self-care is not glamourous. Genuine self-care is mundane, healthy habit-forming behaviour. It's a sensible diet, regular exercise and good sleep hygiene. Self-care at work is proper debriefing, supportive conversations after adverse events and sharing your mistakes so we learn from one another (and so no one feels alone when they make a mistake). Learning these simple acts of self-care has improved my mental and physical health, and hopefully these habits will continue to hold me in a good place.

Supuni: Early career FRANZCOG

Great, training is finally over, your letters are in and you think you are sorted for life, right?

Wrong!

I was just at the beginning all over again, but at a completely new phase in life.

My mentors told me to start slow and steady and not to over-commit, which was great advice, but at odds with the concern of not being able to maintain acquired skills, clinical acumen and not have adequate exposure. The privilege of waltzing into filled operating lists and clinics packed with patients was not a given anymore but had to be sought. Diminishing time caring for, and listening to, patients while tackling bureaucracy and systematic inefficiencies were infuriating. Being responsible for all outcomes of your patients, even if it meant just having your name on a sticker, was daunting and anxiety-provoking. Driving into the hospital when you have been called in for a time-critical, challenging delivery is everything but a joyride and such were the trials and tribulations of a new consultant, to name a few.

As a consultant, you finally have the independence to shape your work-life balance to what you want it to be. Acknowledging and being honest about one's limitations and boundaries (as a clinician, spouse, parent, child, friend), accepting that perfection is impossible, having compassion for yourself and reassurance that you are never (usually) on your own are essential for coping and enjoying the journey. Ultimately, caring for oneself is necessary to be able to care for others and retain the enthusiasm and fulfilment of working in the field of women's health in the long journey that I have loved being a part of and intend to continue for a long time to come.

Greg: Later career FRANZCOG

Pressures change throughout our careers. On reflection, I have become more aware of pressure over the years and more attuned to the pressures I place on myself (e.g. my expectations) and also external pressures (e.g. public hospital electronic medical record systems!) of which I have much less control. I also more readily recognise pressures outside of work. I know that when I have a lot of personal life pressures, I do not manage work pressure as well as usual. Having a better understanding of my limitations means that I can choose to step back from high-pressure situations when I am feeling overwhelmed. I have also become more aware of the importance of developing adaptive strategies for managing pressure. For me, running, talking to friends/family/colleagues, mindfulness and adequate sleep (not always easy!) are mainstays. However, we all need to be vigilant for less adaptive strategies creeping into our lives (such as substance use, binge eating, risky behaviours).

Pressure is not the same as stress, according to the World Health Organization, when pressures become excessive this can lead to stress, which can then become detrimental to health and work performance. This can potentially lead to issues such as burnout and depression. The degree to which pressure is experienced will depend on factors such as whether work demands are matched to knowledge, skills, abilities and available time, and the degree of control the individual may or may not perceive. Support provided in the workplace, especially from colleagues and senior staff/supervisors, are also important.

Pressure is part of nearly all workplaces, but especially applies to medicine. We can think of burnout as one of the undesirable outcomes of the pressure/stress spectrum. A survey reporting high levels of burnout amongst obstetricians and gynaecologists should come as no surprise.[1] Burnout comes with reducing productivity outcomes including academic output, reduction in clinical hours, use of sick leave and ultimately intent to change careers,[2] as well as consequences in terms of health and wellbeing.

However, pressure in our workplaces should not been seen entirely as detrimental. If there is no pressure, we potentially become bored, inattentive and our work performance (and satisfaction) suboptimal. As work pressure increases, we reach an optimum point of performance, probably near the edge of our 'comfort zone' where we are stimulated and engaged, but not excessively stressed. If pressure continues to increase, we risk moving to a stress response situation with burnout and other adverse consequence likely to occur.

Pressure is important for our professional growth and development, it can, however, be detrimental. It is essential for us to be aware of the pressures in our lives and to recognise when pressure reaches the point at which it is detrimental. The pressures we are subjected to are sometimes within our control and sometimes not, and these pressures will change throughout our lives and our careers. It is important that we develop adaptive strategies for managing pressure as these will help us to flourish in both our professional and personal lives.

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Adverse events: when your care does harm

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The redoubtable Henry Marsh, a recently retired neurosurgeon, describes in his candid, compassionate book the difficulty in approaching a patient harmed by one's care:

> ...it feels as though there is a force-field pushing against you, resisting your attempts to open the door behind which the patient is lying, the handle of which feels as though it were made of lead, pushing you away from the patient's bed, resisting your attempts to raise a hesitant smile. It is hard to know what role to play. The surgeon is now a villain and perpetrator, or at best incompetent, no longer heroic and all powerful. It is much easier to hurry past the patient without saying anything.[1]

Henry Marsh did open the door for the first of several important conversations. His patient had developed paralysis in one arm after intricate brain surgery. The paradox is that when empathic connection with our patients is most important, with their worries as to what this means for their future life and plans, it is also a time of vulnerability for us; the involved clinician. What we value most is our reputation; will this adverse event (AE) damage my career? Did I make a mistake or is this a complication despite my competent care? Will my colleagues support me if there is an investigation? The communication skills we need to 'be there' for our patients will be lacking if our own frayed emotions are not controlled. From my medico-legal experience, most of us need help and support at these times. Literature describes powerful feelings of guilt, incompetence or inadequacy following an AE.[2] Our suffering has even led to the concept of the 'second victim'.[2] Too often there is nobody to provide support. The end result can be a clinician in emotional pain, suffering in silence, with patients at increased risk as a result of such distraction.

Yet most organisations surely have untapped supportive resources. University of Missouri Health Care became convinced clinicians were experiencing high degrees of suffering following an AE. They showed one in seven reported a patient safety event within a year that caused anxiety, depression or concerns about ability.[3] Often the clinicians felt they had failed the patient. Alarmingly, 68% reported they received no institutional support. Interviews showed most had a meticulous memory of the event, even details of the date and the colour of their scrubs. Half described the event as life altering. The effects were more severe if the patient was of similar characteristics to one of their own family members, was a paediatric patient or there was a longstanding professional relationship.

Though there was individuality in coping skills, six predictable recovery phases occurred:

1. Chaos and accident response
2. Intrusive reflections
3. Restoring personal integrity
4. Enduring the inquisition
5. Obtaining emotional first aid
6. Moving on

I believe part of the recovery for AE-associated clinicians is to be collaboratively involved in the learning that results from investigation. It reduces the potential of feeling polarised from our service. However, we need more, yet may feel stigmatised by requiring assistance. UMHC's support team are embedded on every shift in high-risk clinical areas so no clinician goes home after an AE to suffer alone.[5] Such debriefing is perhaps the gold standard.

Recognising the importance of such assistance, the National Advocacy Unit, Quality & Patient Safety Directorate in Ireland developed the **ASSIST ME** model[4] consisting of:

A: Acknowledge with empathy the event and the impact on the member of staff.
Assess the impact and their ability to continue normal duties. Example: 'I came to see you as soon as I heard... This must be very difficult for you.'

S: Sorry. Express regret for their experience: 'I'm so sorry this has happened – despite our best efforts, things can go wrong.'

S: Story. Allow space for them to recount what happened, using active listening skills: 'Would you find it helpful to talk about what happened?'

I: Inquire. 'Is there anything I can help you with at this time?' 'Would it help if I told you what happens next in relation to the processes involved?'

S: Supports and Solutions. Provide information on the supports available. Formal debriefing within 48 hours: occupational health department/employee assistance program/mental health services/ psychology services such as counselling, crisis intervention.

Provide informal emotional support 'My door is open for you. I'll check in with you regularly... In the meantime, if you wish to talk, give me a call.' Practical support may involve time out from their clinical duties, or different duties, though many staff find it more helpful to remain at work.

T: Travel. Meaning, travelling with the individual needing support. Providing continuing support and reassurance going forward and throughout the review process: 'I'm here to support you, every step of the way.'

M: Maintain contact. Monitor progress. Moving forward. Ensure there is continued contact with the staff member to prevent feelings of isolation.

E: Evaluate. Establish when the staff member has reached a stage of closure from the event as it is important at this stage not to keep re-opening it. Leave your door open if they require further assistance later. Consider feedback and establish any learning that may benefit other staff.

It is obvious that much of the above involves assistance from others.

The self-help component is about making sure you are open to such assistance!

I am encouraged that more is being done by employers, but that will be insufficient alone. We need to be the owners of our own outcomes. We too rarely take advantage of available support, knowledge and resources. We need to understand our own needs and nourish them. Practical self-care includes:

- Realising that the incident bothering you is part of the normal recovery curve
- Talk to a friend/colleague about your experience and your feelings to reduce feelings of isolation and stress
- Participate in staff debriefing sessions
- Ensure you are involved in, and kept informed of, review of the event; it assists your own closure

Determine your stress management strategies and use them frequently – sufficient sleep, regular exercise, healthy diet, regular relaxation and leisure activities all counter stress. Spending time with family and friends is important. If you have difficulty sleeping that lasts for more than a week, see your GP.

Schwartz Rounds deserve mention. In 1995 Kenneth Schwartz, a 40-year-old healthcare lawyer with terminal lung cancer, was admitted to Massachusetts General Hospital.[5] Shortly before his death, he wrote:

> I realize that a high-volume, high-pressure setting tends to stifle a caregiver's inherent compassion and humanity. But the briefest pause in the frenetic pace can bring out the best in a caregiver and do much for a terrified patient. It has been a harrowing experience for me and for my family. And yet, the ordeal has been punctuated by moments of exquisite compassion. I have been the recipient of an extraordinary array of human and humane responses to my plight. These acts of kindness – the simple human touch from my caregivers – have made the unbearable bearable.

From his work in healthcare law, he was aware of the pressures of resource constraint and therefore how difficult it could be for staff to remain empathic. It is extraordinarily challenging for us to provide even the simple precious moments of humanity that Schwartz referred to if we do not also nourish and work in a supportive environment. His family created the 'Schwartz Center Rounds' in 1997, now adopted by over 400 hospitals across North America, the UK, Ireland and Australasia. The essence is an hour-long opportunity for staff from across whole-hospital settings to get together to discuss difficult emotional and ethical issues that arise in their day-to-day work; the human dimensions of care as they occur to them. Discussion is intended to allow any or all difficulties that hospital staff face at work and can be wide-ranging. It may be on chosen topics such as breakdowns in communication or mistakes in care and even aspects of alternative care options or spirituality. The meetings are led by an experienced facilitator who crystallises and assists in staff exploring emerging themes, ensuring that everybody has a speaking opportunity.

Though evidence as to effectiveness is anecdotal, in a BMJ study[6] staff made comments such as: 'Very human emotional issues get discussed that perhaps we don't voice that often ... but what has been interesting is being voiced in a wider public forum and everybody being able to relate to it.' And: 'I think it is very healthy to be exposed to other networks, other disciplines, other people and go, "oh they have the same kind of stresses as we do."' No study has demonstrated a negative impact. I believe that such rounds help to create a psychologically safe workplace environment that can encourage the development of resilience in individuals and teams.

I invite you to assess the support provided to clinicians in your organisation after major AEs. Do you know the resources available? Formal and informal? Who would you look to for support to maintain resilience? Would you feel safe in seeking it? If you feel that support is inadequate in your organisation, form a coalition, find like-minded people and start the conversation toward ensuring that competent support is created; you with your leaders.

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RANZCOG: supporting your self-care

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RANZCOG has people, services and resources dedicated to help you look after yourself. We want you to be healthy, connected and fulfilled in your work as an O&G, whether you're an experienced Fellow, an SIMG or a new trainee just starting out. Whatever your career stage, it's okay to be not okay – we're here for you, especially as the health system adapts to deal with COVID-19.

Every day, we act to challenge the culture that says asking for help is a sign of weakness, that taking sick leave is not an option, or that you're the only one who's not coping. It takes courage and self-insight to reach out for support, and it can be a relief to know you're not alone.

We recognise that there are limits to self-care. Organisational and systemic factors outside of your control can greatly impact your wellbeing.[1] If we focus solely on the individual, 'we risk ... investing resources in sticking plasters when the necessary treatment is a major operation'.[2] With that in mind, here are some ways we can help you practice self-care.

College support

Our Member Support Program, Converge, provides confidential support to RANZCOG trainees, SIMGs and Fellows (and their immediate family members) across Australia and New Zealand. You can speak to qualified and experienced counsellors on any issue, such as mental health, personal or work relationship difficulties, legal support or coaching advice for supervisors. All sessions are entirely confidential and your first four sessions, within any 12-month timeframe, are fully subsidised by the College. Sessions may be face-to-face, by video conference or by phone. To book a session, call Converge on 1300 687 327 (Australia) or 0800 666 367 (New Zealand).

We are establishing a Wellbeing Working Group, which will be made up of a diverse cross-section of members and trainees. The Working Group's aim will be to consult on, determine and establish wellbeing initiatives and functions that provide support for trainees and members throughout their training lifecycle and working life. Dr Paul Howat (FRANZCOG) will be Chair of the group and Dr Katrina Calvert (FRANZCOG) the Deputy Chair.

Carly Moorfield works in the Training Support Unit as a point of contact for trainees who may be struggling with training, work or personal issues. Trainees can call or email Carly for a confidential conversation about what's happening, what you need and what you might like to do next. Trainees can opt to remain anonymous.

Clare Wells is the College's Wellbeing Coordinator, a new position that will coordinate wellbeing initiatives for members, trainees and College staff. She will support the Wellbeing Working Group and is also available to contact if you wish to discuss anything related to your wellbeing.

The college is currently reviewing a number of educational resources and programs that support the wellbeing of members and trainees. This includes the Respectful Workplaces face-to-face workshop, which educates individuals on unacceptable behaviours in the workplace and provides strategies and tools to establish a safe working environment. We are also evaluating how to better support, prepare and educate Training Supervisors by reviewing the Training Supervisors workshop. If you have any queries, please contact Szabina Szabolcs, Education Programs Lead at sszabolcs@ranzcog.edu.au .

Resources

Our member support and wellbeing hub contains a host of resources to help you take care of yourself, including a list of external support services in Australia and New Zealand. https://ranzcog.edu.au/members/member-support-and-wellbeing.

You can also access:

- the RACGP's Keeping the Doctor Alive: a self-care guidebook for medical practitioners
- the AMA's fatigue risk assessment tool

See also the RANZCOG guideline, Fatigue and the Obstetrician Gynaecologist (under review). https://ranzcog.edu.au/statements-guidelines.

We care about you and are here to support you, whatever the stage of your career. If, as you read this, you are reflecting on your wellbeing and feeling like you might need some extra help, be sure to check out our resources, or contact us for a confidential discussion.

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Port Moresby General Hospital seeking FRANZCOG advanced trainee for 6-month position from July 2020

Over the last 10 years, a number of advanced trainees have undertaken a 6–12 month rotation in the O&G department of Port Moresby General Hospital (PMGH) under the supervision of Prof Glen Mola and the team of six PMGH O&G consultants.

Those who have taken a full senior registrar term at PMGH (all of whom are now specialists in the Australian/NZ health systems) include: Skanda Jayaratnam (Cairns), Namiko Atleker (Darwin), Hang Chau (Albury), Judy Omandy (NZ), Rebecca Mitchell (Melbourne). Gaya Jayasinghe (Sydney) is scheduled to spend February–August this year as an advanced O&G trainee at PMGH.

We seek expressions of interest from advanced trainees to come to PMGH for six months for advanced training from July 2020. There is some funding support available to cover accommodation costs; however, currently no salary is offered. It's worth noting that often registrars are able to get living expense support for global health or international developing country training positions by application to your local RANZCOG state committee. In the future, ideally, this position is funded and supported by the Australian Volunteers International Program.

Further information is available about application, approval of training through RANZCOG, living conditions in Port Moresby and the O&G service at PMGH (detailed annual reports) from Prof Glen Mola (glenmola@dg.com.pg) or Dr Gaya Jaysinghe (gayathri.j111@gmail.com).

There is no doubt that any (even slightly adventurous) Australian or NZ advanced trainee would find a six-month rotation as senior registrar at PMGH fascinating, challenging and very useful, especially for anyone hoping to be a general regional O&G specialist, as there are greater opportunities in open gynaecology operating and operative obstetrics.

Prof Glen Mola
FRANZCOG

Mandatory reporting a barrier in Australia

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It is hard to imagine writing anything right now that does not relate directly to the COVID-19 pandemic. I welcomed the invitation to write about how doctors look after themselves, particularly those in an emotionally and physically demanding craft like obstetrics and gynaecology. I intended to reflect broadly on my personal involvement in lobbying the Council of Australian Governments (COAG) Health Council to change the mandatory reporting requirements in the Health Practitioner Regulation National Law (National Law), and my contribution to amending the World Medical Association's Declaration of Geneva. The changes to society and medical practice created by the pandemic further emphasise the issues at play in doctors' health, and how they affect the care we provide our patients.

The mandatory reporting provisions in the National Law present a major impediment to doctors taking care of themselves.

The National Law initially covered 14 health practitioner groups registered with the Australian Health Practitioner Regulation Agency (AHPRA). The National Registration and Accreditation Scheme commenced in Australia on 1 July 2010 in all jurisdictions except Western Australia (WA). The Australian Medical Association in WA successfully lobbied then Health Minister Dr Kim Hames to allow an exemption from mandatory reporting by treating doctors.

The WA Parliament accepted the medical profession's arguments on this issue. Consequently, in that single jurisdiction, there is an explicit exemption from mandatory reporting for treating doctors. WA joined the national scheme on 18 October 2010, with that major amendment in place.

The AMA, during my time as President (2016–18) and beyond, has called for changes to the reporting scheme so that doctors from the other seven states and territories are not prevented from seeking medical treatment.

Doctors are also patients, and at the very least should have equal rights to their own patients in access to medical care.

The unintended consequences from the operation of the current law are far reaching, with doctors and their families suffering and, ultimately, the existence of a health system that is less safe for patients.

Doctors and other health practitioners have the highest suicide rate in Australia's white-collar workforce, according to data from the National Coronial Information System. In the four-year period of 2011–14, there were 153 health professionals who died as a result of suicide.

Medical practice is stressful and demanding. Doctors are at greater risk of mental illness, of stress-related problems, and more susceptible to substance abuse.

A study of over 12,000 doctors undertaken by Beyond Blue in 2013, revealed that one of the most common barriers to seeking treatment for a mental health condition was concerns about the impact of it on their registration (34%).

The report highlighted the fact that 52% said a fear of lack of confidentiality and privacy was a barrier to treatment – an issue closely related to the fear surrounding mandatory reporting.

There is no evidence to suggest diminished patient safety in WA. In fact, healthy doctors are better placed to help patients. The issues surrounding mandatory reporting have consistently been raised by doctors as a significant barrier to seeking help at an early stage of their illness.

The mandatory reporting requirements for doctors has a two-fold effect: some will not seek treatment at all, and those who do seek treatment may not divulge all the necessary information to receive appropriate care.

Doctors Health Advisory Services reported a significant fall in the level of contact from medical practitioners following the introduction of the mandatory reporting regime. There is anecdotal evidence to suggest that some practitioners have travelled to WA to seek care, safe in the knowledge that they do not have to worry about a mandatory notification by their treating doctor.

The current mandatory reporting provisions, in practice, have commonly been interpreted as requiring a doctor who is treating another doctor who they believe to be in some way impaired, to report that doctor to AHPRA.

Further, the wording of the National Law has been interpreted to provide a very low threshold as to when a notification must be made by the treating practitioner. This is because treating doctors, naturally, seek to limit their risk.

It is critical that every health practitioner can have the confidence to access medical care in a timely way so that health conditions are diagnosed and treated early. Confidentiality is fundamental to the doctor-patient relationship, including cases where the patient is a health practitioner. It is critical that if a health practitioner seeks treatment, that they can have an open discussion about their symptoms so they can be properly diagnosed and treated. This is the only way to avoid the impairment issues that may put patients at risk of harm.

The AMA consistently argued that this situation far outweighs the risks posed by an exemption for treating practitioners from mandatory reporting.

The design of the National Law was to protect the public from unsafe doctors. No government has produced evidence to demonstrate that harm to patients could have been prevented if a health practitioner's treating doctor had reported them to the regulator. The reality is that most health practitioners become aware of risk of harm to patients by another practitioner while working with them.

The WA model does not in any way alter a doctor's ethical and professional responsibilities to report a colleague who may be placing the public at risk.

The introduction of the exemption did not reduce the rate of mandatory reporting in WA, indeed the opposite; 92% of mandatory reports were made by colleagues and employers.

AMA members at the 2017 National Conference unanimously passed a motion calling for the urgent removal of mandatory reporting laws across the country, reflecting the strength of the concern within the profession. We recommended adoption of the WA model nationwide to remove inconsistency around the rules for treating doctors.

I recall the day I addressed the state and territory health ministers very well. The failure of the COAG Health Council to act on the AMA's advice at that time means that we still have a situation where doctors may avoid seeking care. By extension, this raises the risk of harm to patients when their doctor is impaired. A great opportunity to act was squandered.

A suggested compromise was to adopt the WA model, but maintain a mandatory requirement to report sexual misconduct. The amendments made to the legislation in Queensland seek to have the treating practitioner try to make a judgement about 'future risk'.

Again, it is the uncertainty that has doctors fearful of accessing the basic healthcare they deserve. There is much work still to do on this front.

There is little that cause doctors greater stress than medico-legal matters. Being involved in a civil negligence claim is bad enough. Complaints to the Medical Board and AHPRA, with sanctions including loss of registration, are a source of great anxiety. Medical indemnity providers are important sources of advice and practical support. MDA National's 'Doctors for Doctors Program' is a confidential peer support service for members during a medico-legal matter. Doctors who provide this service are exempt from mandatory reporting obligations, so members can share their concerns freely with a peer who understands their profession and the personal impact of facing a medico-legal matter.

One of the highlights of my term as AMA President was election to the Medical Ethics Committee of the World Medical Association. At the 68th WMA General Assembly in Chicago, we approved only the fifth amendment to the Declaration of Geneva. Dedication to the service of humanity, maintaining the utmost respect for human life and maintaining the health and wellbeing of patients as the primary consideration remain at the centre of the modern physician's oath.

However, a new line further strengthens this important document:

> **'I will attend to my own health, well-being, and abilities in order to provide care of the highest standard.'**[1]

Thus, for the first time, self-care is part of ethical medical practice and within the oath that unites medical practitioners from every corner of the world.

As we consider the evolving COVID-19 pandemic, another threat that permits no 'consideration of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor'[1] in its impact, it is worthy of considering that conflict that might be seen to arise when medical practitioners put themselves at risk in caring for their patients.

Healthcare workers should never be put in a position where fears about the adequacy of personal protective equipment interfere with their duty to the patient.

The responsibility of those that govern us, from our parliaments to our health services and hospitals, is to protect us, both with appropriate legislative and governance frameworks, and the physical resources to self-care.

Anything less is to put us in breach of our code of ethics and our responsibility to our patients.

Reference

1. World Medical Association. WMA Declaration of Geneva. 2018. Available from: www.wma.net/policies-post/wma-declaration-of-geneva/.

Life admin: how to lighten the load

Mia Northrup
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Co-host and producer, Life Admin Life Hacks
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You're a medical professional, but at home you may also be chief bill payer, gift buyer, tax agent or meal planner. You're the one who knows the internet contract has expired and you should be shopping around for a better deal. You've noticed the car needs servicing and there are still no plans for Father's Day. You're running your personal and professional life, and possibly the day-to-day logistics of children or your partner. You may find yourself stressing about tasks not done and decisions not made when you'd rather be focused on the patient in front of you, or your child, or your book, or falling asleep. Life admin – those personal administrative tasks and chores that make our lives work – can easily become overwhelming.

Life is generally more complex these days. We live in an era with abundant choice, more regulation and more expense. We get to choose who provides us with electricity, what plan will suit us best, how we wish to pay and how often. We get licenses to fish and permits to park outside of our homes. We sign up for broadband and streaming video plans, dealing with paperwork that our parents never had to encounter as young adults. Contemporary life demands more decisions, more forms to fill out and more fees to pay.

You are not alone in feeling that life admin has exploded and takes up too much of your time. Life admin contributes to anxiety, resentment and friction between couples as the to-do lists grow and the roster of tasks never ends. And it's not just the execution of admin tasks that contribute to these feelings, it's also the mental load that accompanies them. The mental load, or emotional labour, is the anticipating, planning and consideration that is required to keep chaos at bay. This loss of headspace is usually carried by one person in a household, and it is invisible, persistent and stressful.

When it comes to life admin, having the right tools and systems can make the difference between things feeling totally on track or completely out of control. It also helps to share the mental load within a couple or family, so one person isn't on point for the smooth running of the household.

Free up headspace for more peace of mind

You'll have more energy and clarity to put towards substantial tasks once you set foundations that enable smooth processes:

- Get a password manager and stop trying to remember passwords for the online tools you use at work and home. Password managers plug into your web browser and run as an app on your smartphone, and can create strong, secure passwords when required. They automatically fill in your passwords for online forms, giving you one less thing to think about.
- Go paperless. Free yourself from paper clutter, which accumulates in hot spots around your home and office. Those messy zones can drain your energy just by thinking about them. Opt for online or emailed statements, bills and communications, which can be saved, if necessary, in cloud storage instead of requiring manual filing, recycling or shredding.
- Set up a shared calendar for your household so there is more transparency about your family's commitments and events. A single point of truth makes it easier to determine who needs to be where when, and gives visibility to how much activity and running around is required. A shared calendar capturing all the salient details of activities also enables those activities to be executed by others more readily. Moving to a digital calendar means you can refer to it on the fly, add to it in real-time and know your true availability.
- Schedule the inevitable, the inspirational and an hour of power. We're used to scheduling tasks and commitments for work, but often neglect this useful practice in our personal lives. You know you're going to need a haircut, a dentist appointment and a car service this year. Proactively schedule these inevitable, regular activities when it's convenient for you instead of reacting to them. Make time in the calendar for the activities that nourish you and align with your aspirations. Trips with friends, mountain biking, date nights – if they're scheduled in a calendar they're more likely to get done. Schedule time also for dealing with life admin, instead of erratically dealing with urgent rather than important tasks. Consider how you might dedicate time to your to-do list tasks. Allot an 'hour of power' each week, fortnight or month, for tasks that require a focused effort. Identify which items in your to-do list are 'ten-minute time killers', which can be done in idle time. Lastly, avoid putting brief tasks on your to-do list at all. Think 'two minutes, too easy.' Quick tasks can be done immediately, as they arise, giving you a sense of progress and accomplishment.

At the workplace

- Schedule a weekly slot for CPD, where you can read the literature, watch a webinar or research potential courses and conferences to attend.
- Create an email filter to assign industry, professional association and course provider newsletters to appropriate folders so that your inbox remains uncluttered. Use your CPD time slot to review them.
- Consider how the way you work contributes to the life admin of your patients. Do they have to call to make an appointment or respond to your schedule of dates, or can they conveniently access appointment times online? Can they save an appointment event directly into their digital calendar? Do you provide hard copies of paperwork that might contribute to their paper clutter, or could the same material be provided in soft copy to be filed in cloud storage or read and deleted? Do you provide advice on how long documents need to be kept for? Navigating the healthcare system, especially Medicare and private health insurance, can also increase the life admin burden for patients. Offer clarity in the tasks they need to do with various providers and services, to provide peace of mind and to save your patients' time and money.

When the extent of your life admin triggers feelings of overwhelm or tension, it can undermine other self-care practices you put in place. It's difficult to be present and mindful, to relax and get grounded with a litany of admin tasks flitting through your mind. Invest a few nights or a weekend to set up these useful tools and kickstart new habits to minimise, automate and share your life admin more easily. The saved time is then yours to direct towards something truly more rewarding and meaningful.

Admin action stations

From this day:

- every bill or statement that arrives in an envelope will trigger you to set up an online account and opt into paperless communication.
- buying birthday or Christmas gifts is no longer the domain of one person in your household.
- you will never again attempt to compare every provider in the market before you switch plans for mobile, internet or health insurance.
- getting a friend's recommendation for a solicitor to draft a will and powers of attorney is a top priority, if you're yet to do so.

Password manager pointers

Password managers work by remembering all the individual passwords to the sites and apps you use. All you have to do is remember the master password for the password manager, and then it does the rest. When you visit a new site, it will ask whether you want to create a password or store an existing password for the future.

Why bother with a password manager?

- Have login details populated automatically
- Generate strong passwords for better online security
- Fill online shopping forms with payment and shipping details automatically
- Have a consistent password tool across multiple devices
- Use their secure data vaults to store any information securely, such as Wi-Fi passwords, passport numbers or credit card details

Lastpass (www.lastpass.com) and Keeper (www.keepersecurity.com) are available to test via free trials.

Mia Northrop is co-host and producer of the Life Admin Life Hacks podcast at http://lifeadminlifehacks.com, a podcast that gives you back time, money, peace of mind and household harmony.

Self-care in a busy O&G unit in Papua New Guinea

Dr Mary Bagita
Master of Medicine (O&G), UPNG
Division of O&G
Port Moresby General Hospital, PNG

Port Moresby has a population of about half a million people. Urban migration – especially by people from warring tribes in other provinces of the country, those seeking better economic opportunities, and increasing births – has seen a sharp rise in Port Moresby's population in recent years, as well as health problems and strain on the health workforce and resources. A quarter of this population (about 125,000) is female over 15 years of age, potentially needing obstetric or gynaecological care at some point in their life.

Port Moresby General Hospital is the only public hospital in the nation's capital, and serves as both the University's teaching hospital and the national referral hospital for the country.

The O&G division is run by six–eight consultants, 14–16 training registrars each year, and six–10 residents on four-monthly rotations. While the number of residents and registrars has increased slightly from what it was ten years ago, the number of births has also increased beyond the capacity of the hospital. To give some perspective, in 2009, just over 11,000 babies were delivered, rising to reach a peak of 15,000 in 2014. The following three years seemed to see a decline in births to 13,000–14,000, and while this was happily attributed to the introduction of the Jadelle implant, our hopes at seeing a further decline in births over the last two years seem to be fading. In 2019, the hospital delivered 14,500 babies.

The number of deliveries alone shows the volume of patients passing through the O&G unit. In addition to labour and delivery care, the rest of the unit, made up of some 200 beds, includes a 96-bed postnatal ward and an antenatal and gynaecology ward.

Much of the leg work and day-to-day management decisions of a patient is really dependent on the efficiency of residents who are running between and/or ringing labs, inserting cannulae and catheters, urging relatives to donate blood, preparing for presentations, and so many other things in addition to formally admitting and discharging inpatients.

Registrars do much of the clinical work assisting and supervising residents, contributing to running a service and simultaneously training as a specialist (including reading widely, preparing for seminars, and meeting postgraduate requirements). While running a service is important, it can be quite overwhelming trying to find a balance between service and training. Cultural ties are strong and the added social pressures from family, both immediate and extended, can take a toll on any clinician.

Being on-call requires both physical and mental preparation. As a resident, we did a 32-hour shift every four days – working your usual eight-hour day duties, taking the call from 4pm to 8am the next day, and continuing your normal (eight-hour day) duties the next day. One was lucky if you could have a power nap for half an hour, let alone read your own handwriting the next day. Thank goodness for the resilience of youth and being single, my peers and I survived the four months of a hectic O&G rotation at the end of which, I had made up my mind O&G was not for me.

Ten years later, as a registrar and married with young children, on-call hours had not changed significantly, but my life had. Aside from taking calls every four to six days, progressing to two registrars on-call towards the end of my training, the 32-hours had not changed. Recovery from an on-call shift took two days. Juggling between work, training and home would not have been possible without the support of family and the collegiality of the O&G family. One day every weekend was spent with my family, usually at church in the mornings, and then a lazy afternoon at home or the beach before returning to church to close the day. I found the one day each week attending church – meeting non-clinician friends who shared similar beliefs, being involved with music and children's activities completely different from the work environment – contributed immensely to relieving the stress and pressures of work and study, and helped to reset the faculties for the coming week.

Ten years ago, I completed my O&G training and transited from senior registrar to junior consultant (glad that I no longer had to stay full time in the hospital when on-call) and visions of all the extracurricular things I could do in my 'free' time flashed across my mind. My visions of immense joy in this new-found freedom from 32-hour calls lasted only about a year. I soon discovered that being a consultant involved a whole new level of responsibilities apart from the routine clinical care of patients. It was a time to improve my clinical and surgical skills, but it also involved more administrative duties, training responsibilities, O&G Society duties,

and responsibilities at the national level – most of it done in good faith. Continuing a weekly rest with my family, being involved with my children's extracurricular activities (including camping and hiking) all helped keep a mental focus on things. The progression of years has brought with it more responsibilities; so much so that there are times I feel like I have three or four full time jobs. It's during these times that too many expectations result in more mental anguish and stress and the impression of inefficiency. This is when delegation is important, and when delegation is not possible (as is often the case), it is also alright to refuse to accept extra responsibilities. I have recently convinced myself that unless it is absolutely necessary, it is also alright to not come into the hospital when not on-call.

Aside from clinicians taking care of themselves, mentally and physically, I believe it is also important that a suitable work environment is created in order for them to do so. Over recent years, the O&G unit has tried various ways of reducing or breaking up the 32-hour call period in the hope of allowing registrars more rest and better and faster recovery following on-call duties, so that they have sufficient time for their training needs. This is still a work in progress. An understanding between colleagues who are able to support each other when a need arises is crucial. And finally, the support of family cannot be understated.

Thinking within the box, that is, continuing as we have always done, will keep us where we have always been. Thinking outside the box, while good for innovation, usually results in unrealistic goals. Thinking about what we can do with the box, that is, what we can do with what we have, is more realistic. I have hope and believe that small, simple changes in the way we do things can have a big impact on practice – including improving our working hours.

2021 | RANZCOG **Annual Scientific Meeting 2021** Hobart

A VISION FOR THE FUTURE

14-17 February 2021 | Hotel Grand Chancellor, Hobart, Tasmania **ranzcogasm.com.au**

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) invites you to attend the 2021 Annual Scientific Meeting (ASM) in Hobart, Tasmania.

The RANZCOG 2021 ASM Organising Committee is planning an engaging and invigorating program to re-inspire you as we navigate through these uncertain times. The following pages highlight some of what we're planning: stay tuned for further updates including well-being activities and virtual event attendance.

Social Program

New Fellows Presentation Ceremony and Reception

Sunday 14 February

18.00 – 20.00
Tasman Room, Wrest Point Function Centre, Sandy Bay

The New Fellows Presentation Ceremony and Reception will be held on Sunday 14 February 2021. Newly elevated Fellows and recently certified Subspecialists will be joined by family and friends to celebrate this significant milestone in their career. This function will also include presentation of medals for outstanding achievements in RANZCOG examinations, and awarding of Honorary Fellowships and College Medals. Following the formalities, a reception will be held at the same venue.

Includes:	Drinks and canapés
Cost:	Inclusive with full registration
Tickets:	Bookings are required in advance and additional tickets will be available for purchase for family and friends. New Fellows and Subspecialists will be contacted individually with ceremony registration details
Dress Code:	Smart casual

Meeting Dinner

Tuesday 16 February

19.00 – Late
The Museum of Old and New Art – MONA, Berriedale

The Museum of Old and New Art - MONA in Hobart is a mind-blowing showcase of international treasures and contemporary art and is the venue for the RANZCOG 2021 Meeting Dinner. Enjoy an exclusive gallery viewing with canapes, followed by a night of fine food, wine and entertainment... with a twist!

Includes:	Transfers to and from MONA, Dinner and Drinks
Cost:	$190
Tickets:	Bookings are required in advance and additional tickets will be available for purchase for family and friends.
Dress Code:	TBC

Keynote Speakers

Dr Sarah Stock

Dr Sarah Stock is a Wellcome Trust Clinical Career Development Fellow at the Usher Institute at the University of Edinburgh; and a Consultant and Subspecialist in Maternal and Fetal Medicine at the Simpson Centre for Reproductive Health at the Royal Infirmary of Edinburgh. She received her medical degree from Manchester University Medical School and has a PhD from the University of Edinburgh. Her specialist and subspecialist clinical training was undertaken in Edinburgh, with periods in Glasgow, London and Australia.

Her research focuses on preterm birth and how this can affect the long-term health of the child, as well as how to diagnose fetal inflammation, and how to optimise treatments for this issue. Her research into this leverages population health data to explore the effect of environment on pregnancy and the effect of antenatal treatments on perinatal and childhood outcomes.

She now leads data-driven research into pregnancy treatments, including the international Co_OPT collaboration, which aims to establish the effects of inappropriately timed antenatal corticosteroids in babies and children. Dr Stock is also the Chief Investigator for UK large multicentre observational cohort studies inducing QUIDS (Quantitative Fibronectin to help Decision-Making in Women with Symptoms of Preterm Labour) and CHOICE (Cervical ripening at home or in-hospital) studies.

Prof Lesley Regan

Prof Lesley Regan was the 30th President of the Royal College of Obstetricians and Gynaecologists (RCOG); only the second woman to ever hold this role and the first in 64 years.

Head of Obstetrics and Gynaecology at St Mary's Hospital campus, Imperial College London, Prof Regan is also director of Women's Health Research Centre and co-director of the UK Pregnancy Baby Bio Bank. Prof Regan is the Department of Metabolism, Digestion and Reproduction co-chair of the People and Culture Committee (Athena SWAN).

She is also a member of the RCOG Council and International Executive Board, Secretary General of the International Federation of Gynaecology and Obstetrics (FIGO) and Chair of CHARM - the Charity for Research into Miscarriage. She is also PI for the Recurrent Miscarriage Tissue Bank.

Having graduated from the Royal Free Hospital School of Medicine, London, in 1980 Lesley pursued her career at Addenbrooke's Hospital, Cambridge, where she first became enthused by clinical and laboratory research, completing an MD on miscarriage.

Prof Regan combines her clinical and research work on recurrent miscarriage and uterine fibroids with a passion for communicating to the wider public, writing two successful books on miscarriage and pregnancy for the general reader and presenting a series of eight BBC 'Horizon' documentaries. In 2015 she received an Honorary Fellowship of the American College and a Doctorate of Science from University College London for her contribution to women's health.

A/Prof Todd Ponsky

A/Prof Todd Ponsky is currently a professor of surgery at the University of Cincinnati and director of Clinical Growth and Transformation at Cincinnati Children's Hospital Medical Center. He is currently the president-elect of the International Pediatric Endosurgery Group (IPEG), Chair of the American College of Surgeons Committee on Telementoring, and holds leadership positions in APSA and SAGES.

A/Prof Ponsky was the first to perform and report single port surgery in children and modernised the methods of the laparoscopic paediatric hernia repair. He is involved in both outcomes and animal research with a focus on inguinal hernia physiology, surgical telementoring, endoscopic repair techniques for pure oesophageal atresia, and innovations in education. He founded GlobalcastMD and Stay Current in Surgery, both of which serve to modernise the way we teach and learn surgery.

He has published over 100 manuscripts, edited one textbook, and authored over 20 book chapters. He has directed over 50 American andinternational courses and has given over 160 visiting lectureships. He is the associate editor for the Journal of Pediatric Surgery, and serves on three editorial boards.

Dr Bruce Bekkar

Dr Bruce Bekkar is a women's health physician, author, and educator who has been engaged with the climate crisis since 2007. As a full-time activist since 2013, he has worked with numerous local and national United States organizations, including The Climate Reality Project, the American Lung Association, Environment America, and ecoAmerica's Climate for Health Ambassadors Advisory Committee.

A writer and frequent speaker on climate and health, Dr Bekkar has addressed the California State Senate Environment Committee, the American Meteorological Society, Genentech, Citizens Climate Lobby and the Sierra Club. He recently shared original research on the risks to pregnancy in the U.S. at national meetings of the American Public Health Association and the American College of Obstetrics and Gynecology.

Workshops

Preterm Birth Prevention Workshop

Dates:	Saturday 13 February
Times:	10:30 – 17:00
Venue:	Hotel Grand Chancellor, Hobart
Cost:	$600
Includes:	Lunch and afternoon tea

RANZCOG Fetal Surveillance Workshop (FSEP)

Dates:	Sunday 14 February
Times:	9:00 – 16:00
Venue:	Hotel Grand Chancellor, Hobart
Cost:	$350
Includes:	Morning and afternoon tea and lunch

RANZCOG Ultrasound Workshop

Dates:	Sunday 14 February
Times:	8:15 – 16:45
Venue:	Hotel Grand Chancellor, Hobart
Cost:	$1544
Includes:	Lunch and afternoon tea

Diplomates Days

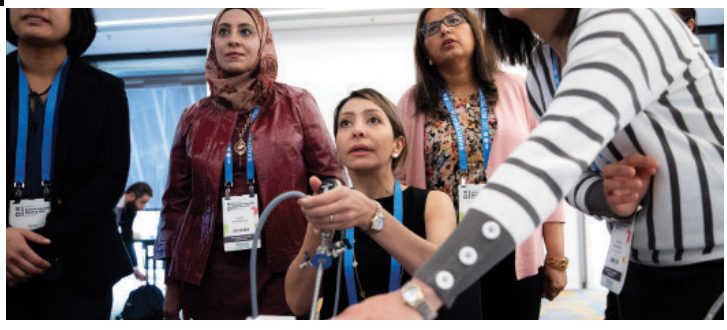
Dates:	Saturday 13 & Sunday 14 February
Times:	8.30–17.00
Venue:	Hotel Grand Chancellor, Hobart
Cost:	$600 daily
Includes:	Morning and afternoon tea and lunch on the day of attendance. One ticket to the Diplomates Cocktail Function on Saturday 13 February.

RANZCOG Training Supervisor Workshop

Dates:	Saturday 13 February
Times:	8:30 – 15:30
Venue:	Hotel Grand Chancellor, Hobart
Cost:	Free
Includes:	Morning tea and lunch

Paediatric and Adolescent Gynaecology Workshop

Dates:	Sunday 14 February
Times:	8:30 – 16:30
Venue:	Hotel Grand Chancellor, Hobart
Cost:	$600
Includes:	Lunch and afternoon tea

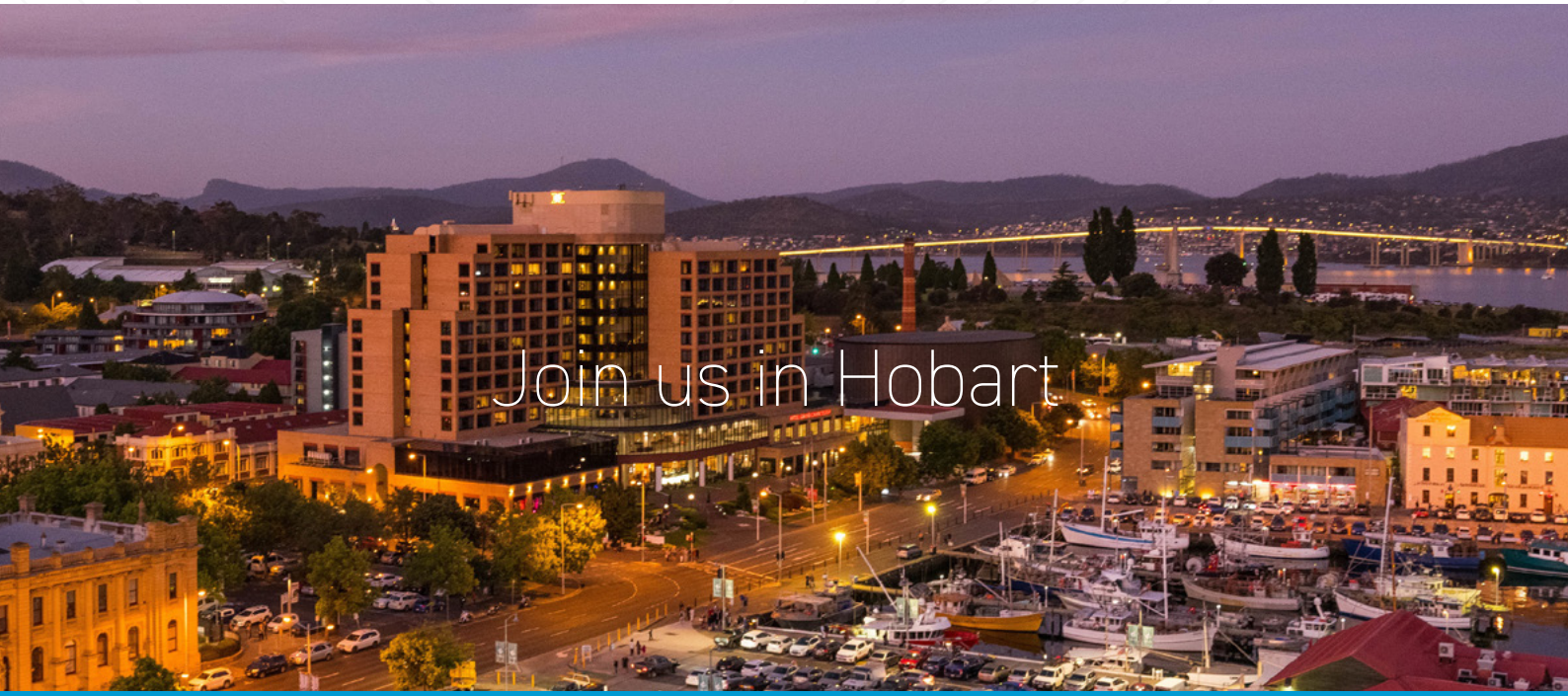


Key Dates

Deadline for receipt of Abstracts
Monday 31 August 2020

Abstract Author Notification
Thursday 8 October 2020

Early Bird Closes
Sunday 8 November 2020



Register before Sunday 8 November 2020
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2020: let's make it our year to rid incivility

Miss Jess McMicking
BHlthSc Nut, MBBS, FRANZCOG
Obstetrician Gynaecologist
Guy's and St Thomas' NHS Trust, London

Incivility carries many definitions across dictionaries; however, as demonstrated in Figure 1, negative connotations commonly associate themselves with this noun.

Figure 1. Definitions for Incivility.

It is hard to believe that a word like this can exist in our medical environment, especially when we consider where it derives from: the Latin world incivilis meaning 'not of a citizen'.

Why is medicine vulnerable to incivility?

When we look at the environment in which we provide healthcare, it is no surprise that as medical professionals, incivility can encroach our everyday clinical shifts.

Those busy hours where everything is done at haste, where manners and simple courtesies are often neglected. The time demands and a pressurised healthcare system lead to long hours and fatigue. The next day brings endless referrals from another specialty, being paged in the early hours of the morning to chart simple analgesia, and frustrations of trying to start an operating list while the equipment 'chooses' to fail.

This list is not exhaustive, but the message is clear.

The environment in which we work can, by default, put us in situations where we are 'uncivil' to one another; abruptly snapping, passive aggressiveness, sniping comments or simply inappropriate workplace conduct and etiquette can occur easily and inadvertently or without deliberate malicious intent. The traditional hierarchical nature of our medical departments can also make us vulnerable to behaving in this manner, with teams being led by the more senior members of the consultant body followed by the tiered system of registrars and house officers.

Whether we like it or not, incivility occurs across medicine. For a multitude of reasons, it is hard to accurately quantify its prevalence and more significantly, its impact, on the medical workforce. However, we can assume it still exists when inferring other research findings.

The UK has been able to capture and provide evidence for incivility and its impact. In a survey conducted across 606 varied English medical doctors published in 2015, up to 40% of staff described rude, dismissive and aggressive communication had a 'moderate-to-severe' impact on their professional daily work, and 31% had been exposed to this behaviour multiple times a week.[1] Only 7% reported they never experienced it.[1]

Whether as a country, a fraternity or a specialty, incivility is prevalent and has potentially insignificant repercussions on happiness at work, productivity and our capability to provide safe and high-quality healthcare.

What happens when one is uncivil?

Incivility has a profound impact on all those within the environment at the time the act occurred, as demonstrated in Figure 2.

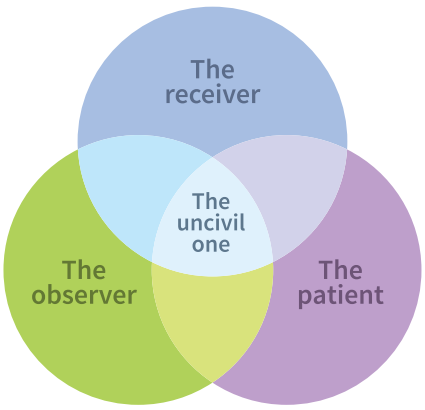

Figure 2. The relationship matrix of incivility.

1. The receiving individual

Rudeness (direct or passive) to one will cause stress to the receiving end, and subsequently result in diagnostic errors, technical performance, and delay in diagnosis and treatment.[2,3] The mechanism is very simple; stress can inflict changes in one's cognitive processing as well as provide distraction to the job at hand. In addition, one may engage in avoidant behaviours, lose focus and never complete the task.

It is difficult to quantify how long impaired performance is sustained after an uncivil incident, given the variation in behaviours, reactions and personalities involved. Given that our daily job requires intense focus as part of providing critical care, our undivided attention to technical skills, and large degree of engagement with our patients, this is concerning.

2. The observing team

The performance of all team members who witness incivility are affected by different mechanisms.

Studies have demonstrated that witnessing incivility significantly decrease one's performance. A study published in 2013 showed that witnesses had a 20% reduction in performance and 50% decrease in willingness to help other members of their team.[4]

Good teams are built on foundations of mutual trust, cooperation, respect for each other, and commitment to achieving a mutual goal. How this gets disrupted when one is uncivil is significant. It not only breeds interpersonal conflicts, but in addition breaks down the teamwork and communication channels, which are critical in delivering high level care and performance.[2,3]

What is reported as being damaged, and in some cases even destroyed, is the 'psychological safety' of the team; impairing innovation, cessation of volunteering opinions and collective goals amongst members.[5]

3. The patient

The care provided to the patient is ultimately compromised, such as medical errors and delays in decision making.[3]

Rude language and hostile relationships between healthcare workers has been associated with serious threat to patient care, as well as a patient's impressions of the care being delivered. The behaviour of the team member(s) can negatively impact the image of the care being delivered, and credibility of highly trained and skilled professionals can be impacted. This is accentuated by the patient often being in an anxious and sensitive emotional state, especially given they are undergoing clinical care in an environment surrounded by unfamiliar faces.

Some areas of medicine have performed controlled simulations to gauge the impact incivility has objectively. A randomised trial performed across 24 neonatal intensive care unit teams, involved an unwell infant and the treating team being exposed to rudeness or neutral comments. Unsurprisingly, results showed the team who was subject to incivility had lower scores in diagnostic (2.6 vs 3.2, p=0.005), and procedural performance (2.8 vs 3.3, p=0.008).[2]

A more recent study, published in 2019, examined anaesthetic trainee performance within a simulated surgical environment. The control group were exposed to a pleasant surgical environment, whereas the other group to a 'rude' environment. Trainees exposed to incivility had a significantly lower performance level, with 63.6% performing at a standard to achieve a pass level versus 91.2% within the control group (p=0.009).[3]

Although these examples are not strictly native to our specialty, we can empathise with these scenarios given their close relationship to clinical situations within obstetrics and gynaecology.

How can we change and become more civil?

Practice in self-care

It is important to take care of oneself, mentally, emotionally and physically. Self-care will result in positive mindfulness; and allow our body to rest, reflect and refocus in time.

Uncivil behaviour can directly and indirectly inflict negativity on ourselves; we lose our vision and our objectivity. We can feel depressed, anxious and stressed, as well as negatively reactive to what is occurring around us.[6]

By taking the time out for oneself, doing something of pleasure and refocusing, this is the best medicine for promoting civility amongst our workplaces.

Civility Saves Lives

This is a UK campaign that was devised initially by a small group of medical professionals who acted to raise awareness of the power of civility in medicine. Since then, Civility Saves Lives has grown into a large organisation that promotes positive behaviours internationally using social media campaigns, clear and powerful infographics, publications and international presentations.[7]

The message is strong. By being aware of our interactions with others and focusing on being civil, it will help reduce error, stress and complications in our clinical practice.

'Civility costs nothing and buys everything'

– Lady Mary Wortley Montagu

To be civil is not expensive. Civility does not require years of medical and specialty school training. It can be taught without the use of textbooks and online resources, by any level of any professional.

Has the time come where we need to embed formal training in civility within our departments? Take a moment to look around you – observe the room, each individual and their interactions. Treat others as you wish to be treated. Say sorry. Ask for feedback at the time of encounters. Do things differently next time. None of this costs money.

Be a leader; to be civil is part of a leader's true characteristics and will enhance not only your performance, but everyone around you.[3]

Although there are things left to be answered, it is time to put a stop to incivility. It can impose a toll on many individuals and our overall performance as a team, department, hospital and system. Let's together in 2020 be proactive. Let's recognise, address and say goodbye to incivility.

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Group private practice: promoting self-care

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The theme of this issue of *O&G Magazine* is Self-Care, or how to manage the stresses inherent in our speciality. Be it physical, mental, emotional, administrative; how to deal with adverse outcomes, the unpredictability of clinical care, effect on relationships outside work. We all know that prevention is better than cure, so in this article I wish to discuss ways of organising the 'work' part of the so-called work-life balance to avoid some of these problems in private practice.

Full disclosure: as well as a past life as an academic, and still doing public work, I am part of a group private O&G practice that has been evolving over 22 years and is still working well. Here I hope to explain some of the good and bad things we have found over this time and also describe other models of practice that may suite different situations.

Where to after gaining fellowship?

According to the College-wide annual survey, 65% of Fellows provide care to private patients, possibly a higher proportion in Australia compared to New Zealand. For those who choose this path, moving from the relatively predictable structure of a training position, with its set hours, hierarchical structure and strict practice guidelines brings with it a new set of problems.

The traditional model of solo private practice involves setting up rooms, employing staff, finding a referral base, gaining accreditation and admitting rights to private hospitals, understanding financial and regulatory issues and deciding what and how to charge for your services. It also means being responsible for your patients' obstetric (or gynaecological) care continuously, unless adequately handing over to a trusted colleague. In reality, this means you can never be more that 20 mins away from the hospital, always sober and never in total charge of children you can't leave.

This model of practice therefore requires commitment, not only from the obstetrician but from family members. In order to manage some of these issues, various alternative models of practice have been tried, as mentioned below. These options are not exhaustive, and hopefully more ideas will be explored as younger Fellows think more laterally about how they want to pursue their careers.

The traditional weekend cover

The commonest way to have time off is to be part of an on-call sharing group, especially for weekend or holiday cover. Individual practitioners form a group of several doctors who take responsibility for the practices of colleagues in a regular roster, so one may be on call one in three, four, five or more weekends, thus covering a multiple number of patients in turn. This may mean being very busy when 'on' but then having several weekends off as compensation. Sometimes these arrangements cover weeknights as well, especially for special events (family or school reasons), or perhaps to recover from a bad run of nights on. Major issues with this model are adequacy of handover, patients' expectations if cared for by a stranger and renumeration between doctors.

Group practice

General practitioners are often organised in groups, perhaps now run by bigger corporate entities, and certain other specialities (such as radiologists, gastroenterologists, dentists) work as groups. Such a model was attempted in Melbourne some years ago where a company built a stand-alone private O&G hospital, then looked for specialists to be employed to care for the hospital's patients. I call this the 'if you build it, they will come', or the 'top-down' business model. It failed, I believe, as it was planned from a business perspective, not from the angle of practising obstetrics in a sustainable manner.

Perhaps one reason for this failure is the particular relationship obstetricians (as opposed to other specialists) have with their patients. We are generally looking after a healthy woman, usually part of a family, for an extended period with a condition that is not necessarily pathological, but carries risk and uncertainty (and has more lay opinion than any other area of medicine.) When women are paying for private care, they often expect to build a relationship with their care givers. Managing patient expectations with good explanations and education about the benefits of shared cover is a major part of group practice. Here the 'pilot analogy' works well; explaining that pilots must have clear times off to recover so as to be ready for unexpected emergencies, much like obstetricians.

One way to go

Our practice, based in a major capital city, began after soul searching as registrars watching how our senior colleagues and mentors ran their lives. At that time, there were far fewer women doing O&G and we started to look at alternative ways of practising that would allow us regular time off. This took over two years of research, contacting groups in the US, doing

a TAFE business course and getting expert financial and tax advice. In the beginning, this was not without challenges and over the years we have tried different ideas, mainly in terms of the on-call roster and ways of billing and paying each other for work done, especially when the members have taken on different workloads and patient numbers, often due to family commitments. We have heard registrars talking about going into group practice now as if it is just another job to apply for, without realising the subtleties of how to share, both clinically and in a business sense. Unfortunately, some groups have floundered if these issues are not clear cut from the beginning.

Our model now has five obstetricians (from the original three, then four), who all do variable amounts of private gynaecology depending on skills and interests. All are RANZCOG training supervisors and do public clinics and on call. Our rooms are onsite where a private hospital is co-located with a tertiary public hospital, which allows us to look after very preterm or high-risk pregnancies. Our on-call roster is planned 18 months in advance, with one of us being nominally responsible for the whole group's patients for 24–48 hours at a time. In reality, we look after our own patients during week days, and plan elective deliveries accordingly, but have the option of a day off, or to handover for the evening and night if we need or want to. We share a suite of rooms and employ three midwives who help with procedures, answer patient enquiries, do CTGs, patient education and occasional routine antenatal care. We are sole traders, but have a Unit Trust running the business and employing several part-time reception staff and a practice manager, and each doctor has a service agreement with the Trust. We share operating lists and assist each other in hours if possible. Our patients are informed of the group system via our website, verbally when they book and receive a detailed email within 24 hours explaining the practice model and its benefits, both to doctors and patients. Our patients book in the name of their primary obstetrician, but meet each of the others at some stage in their antenatal course and we deliver 60–75% of our own patients.

Alternative structures

Other practices have a more strict 'on-call' roster where one doctor looks after all the practice patients for labour and emergencies for a day, and antenatal visits are booked as a clinic where a doctor (or midwife) sees all women who want to come on that day. Many practices now include midwives using their particular skills to enhance the experience of private patients; doing education, lactation support, assessing perinatal mental health, postnatal care (even home visits). Some practises are now including midwife care and private delivery (with obstetrician back-up) for a lower cost model.

I believe some of the more intangible benefits of group practice are its strengths as listed below, not just the obvious time on- and off-call.

Benefits of group practice

- shared costs of running a practice, ability to afford equipment early on (ultrasound, colposcope, steriliser)
- colleagues around to assist, provide advice, backup for family or health emergencies
- multiple opinions for each patient
- shared business responsibilities, employer issues, compliance
- the benefits of having members at different ages and life stages means that there is a range of experience and expertise, and the ability to arrange maternity leave, leave in or away from school holidays, flexibility to change on-call at short notice when child free

Downsides of group practice

- less clinical autonomy, need to have similar philosophy and management principles
- need to compromise on many issues, from décor to financial and clinical decisions
- missing the absolute relationship with a patient
- need for good handover (easier these days with digital options)
- managing some patients' disappointment

Ten issues to consider in group practice

1. Choose personalities that suit, not just bodies to cover the hours. This is one of the main reasons why some groups fail
2. Good communication – sort out issues internally, avoid lack of cohesion apparent to colleagues (corridor gossip), like with any long-term relationship, don't let things fester, be ready to compromise
3. Agree how decisions will be made and how to manage conflict (consensus, voting)
4. Get good financial advice about structure of the business; accountability, avoiding collusion, paying each other
5. Decide how patients are accepted into the practice, individual referrals or equal numbers for each practitioner or book to the practice alone
6. Role of midwives: independent practitioners, employees
7. Plan how and when to handover labouring women, what's best emotionally and clinically, not just deciding who charges for the delivery (for example, handover in early labour rather than when awkward decisions may need to be made at full dilatation)
8. Consider a business 'pre-nup' covering all possibilities: a doctor leaving, becoming incapacitated, de-registered, wanting to decrease hours or take more or fewer patients, provisions for extended leave (maternity, long service, sick), how many weeks of holiday each
9. The use of locums for extended leave
10. How someone joins or leaves the practice (buy in/out)

A good way to test out a new member is for them to cover each doctor in turn, for two to three months, thus allowing extended leave for members and the ability to see if someone new is the right fit for the practice. This is also a good way for new Fellows to gain experience of private work without expensive outlays. Often at this stage of their career, they have the generalisable skills to cover a consultant's public and private commitments, thus allowing someone to have a complete break. Remember, there needs to be a long lead time to plan extended holidays in order to warn patients as they book, so plan to offer services for one to two years hence.

If real estate is about position, position, position, then group practice is about personality, communication and compromise. The above ideas are not exhaustive. New arrangements with private hospitals and midwives may be the way forward with a range of billing options for patients of different risk, wants or needs. Group practice may also allow variable workloads for different stages of a career, and thus ease one into retirement. In the end, the best things about a group practice are the support, camaraderie, clinical backup and planned time off, which avoids burnout and leads to a long-term sustainable career.

Maintaining balance in rural practice

Dr Peter Roberts
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'When one subtracts from life infancy (which is vegetation), sleep, eating and swilling, buttoning and unbuttoning – how much remains of downright existence? The summer of a dormouse.'
– Lord Byron

When I was asked to write an article on the work-life balance, I wondered if I was qualified to do so. Then I thought back to 1987 when I started in rural practice in the picturesque small town of Mudgee.

My working week involved working in the practice, doing house calls, visiting the nursing homes, being on shared call for obstetrics and anaesthetics and doing at least one 24-hour shift in our emergency department. I thought I would do five–10 years in country practice and then move back to the coast to a practice with more civilised after-hours arrangements. Now, 33 years later, my wife and I are still here and are lucky enough to have our daughter and her three children living around the corner.

This was an intense workload and, at the beginning, a fascinating engrossing time. The more work you did the more it would draw you in. Being so needed was endlessly gratifying and deeply satisfying. However, with time, it becomes obvious that this kind of life is disturbingly unbalanced.

Fortunately, the practice I joined was aware of this and had a policy of eight weeks annual leave, 18 weeks off every fifth year, an afternoon off per week and Friday off when you'd worked the previous weekend. This pattern suited me well and I have maintained it long after that partnership dissolved and we were allowed to work whatever hours we thought reasonable. This way of life led to my brother re-christening me Doc Holiday. When one of our registrars asked what holidays he should take, I suggested as many as he liked so long as it wasn't more than me. He was delighted.

The formula of about 10 weeks on then two weeks off seemed to work the best. Two weeks gave you enough time to unwind and reconnect with family and friends without being too obtrusive to the practice. An older patient once told me that the cemetery is full of irreplaceable people. Our patients love us to be there for all of their major health events, but it is just not possible. I respond with a good-natured laugh when my patients say, 'you're not going away again, are you?' I tell them I'm sharpening my axe.

The opportunity to have a break need not be just about holidays. On my first 18-week sabbatical, I spent a month at the Royal United Hospital in Bath doing caesareans to brush up my skills as this was becoming a bigger part of my obstetric practice. The whole family came along and they speak glowingly of those beautiful Bath summer days with hot air balloons appearing soundlessly over the bucolic landscape.

The next long break gave me the opportunity to visit a friend who was establishing a paediatric school of medicine in Blantyre, Malawi. I did ward rounds with him in the morning and visited some of the small outposts providing healthcare in country areas. I was also able to visit the horrifying Zomba Psychiatric Hospital, with its 19th-century management of some very unfortunate people. We went on weekends to scuba dive in Lake Malawi and hike in the magnificent Mulanje Plateau with ancient cedar forests and clear streams full of trout.

One other very exciting opportunity was doing a month rural placement on Vancouver Island in British Columbia. This enabled me to see another nation's health system from the inside and see some beautiful countryside. The GP I replaced interestingly had cut his working week to two and half days to allow more time for sailing round Vancouver Island.

Over the last decade, I have rekindled my love of surfing and have been lucky enough to have trips to the Maldives, Sumatra, New Guinea and West Samoa with a group of old uni mates. The surfing stories are becoming more heroic as the years go by.

Breaks away are an excellent way to reconnect with family and reinvigorate your love of medicine, but day-to-day self management is also vital. Having an excellent practice manager to take away the daily management issues is vital. A sensible appointment

system that doesn't always find you becoming later and later as the day goes on is important. Spending time with your fellow doctors and staff builds team rapport and can be as simple as making it to morning tea break as often as possible. Some time through the week either to catch up on paperwork, read the latest journals or indulge your favourite pastime really helps. Outside medicine it is really helpful to have non-medical friends who can ground you into what a normal life looks like. You will never regret time you spend with family over the years but you will regret the time you don't. Teaching students and registrars is a wonderful circuit breaker from the day-to-day job. Being involved in the community is great if you have time. I have delivered a baby in the afternoon and served popcorn at the movies in the evening for one of our local charities. A retired professor of gynaecological oncology is often helping as well.

I have tried yoga and meditation and have found both helpful. Running or bike riding are excellent to lower stress levels if your joints allow but walking, especially in a natural setting, is equally helpful. Finally, sharing your problems and emotions with someone whose opinion you value is very calming, even if you have already mapped out your course of action. This is a sign of emotional maturity, not weakness.

Everyone's situation is different, and I can of course only discuss what has worked for me and hope these ideas are helpful for you.

Life after O&G: a personal view

Dr Bernadette White
FRANZCOG

As doctors, we approach the possible end of our career as an obstetrician, gynaecologist or GP specialist with a range of emotions. For some, pleasant anticipation, but for others, uncertainty about what will fill the 40, 50 or more hours that are currently taken up with work. For some, the idea of this transition is unthinkable and plans are postponed to a dimly envisaged future. The demands of a career in obstetrics and gynaecology, often combined with family responsibilities, are such that for many of us, there has been limited time to develop other interests that can be a new focus.

As the possibility of leaving one's current career approaches, one of the most important aspects of this time of life is developing a new identity. For most of us, our career means that we are the highly regarded expert, respected by our patients and enjoying the social status that is part of our work. We may have skills that few others possess, or fill important and highly-valued roles in our hospitals. Who will we be if we are no longer in that role? Personal circumstances meant that I had to consider these questions myself in recent years.

Early in my specialist career, I had a naïve and hazy idea that I would work until I was in my mid-50s, then retire to study, travel and do other things that work did not permit. But mid-50s saw me as a busy clinician and clinical director in a tertiary hospital. It was a very satisfying position that I enjoyed, with colleagues that I valued. I felt that I had experience and expertise that was useful for my patients. I loved working with and mentoring our trainees. And I readily confess that I enjoyed the status of that role.

However, six months of chemotherapy for chronic lymphocytic leukaemia meant that the future was a bit less certain and required serious consideration. I had never taken more than three weeks leave, except after babies, so I had a lot of long service leave available. I decided to take six months off and start a full-time course at Melbourne university, studying horticulture. I approached this with some trepidation and was prepared to return to my career if I did not enjoy study.

Returning to full-time study was a surprisingly challenging experience. It was much more time consuming than I expected, possibly because I was, according to my adult children, a 'typical mature-age student nerd' attending every lecture, sitting at the front, asking questions and taking all assessments painfully seriously. I discovered that plant physiology was even more complicated than human and that plant genetics involved things like microarray and CRISPR, which I had never really understood in human genetics! I encountered, and was baffled by, Excel and had to do my own word processing with no secretary, to prepare essays and put in graphics. But I also discovered the wonders of the Islamic garden, how to grow better tomatoes and how to do a basic soil analysis. I learned about the devastation of the Atlantic rainforest in Brazil and how stormwater is a valuable lost resource in cities. I was in a graduate course, so all my fellow students had already studied at university before. Although much younger, they were generally welcoming and friendly and there were a few mature students like me, studying for their own interest. But I did confirm the difficulties of group assignments, thrown together with other students with varying levels of engagement and capacity in the English language.

Apart from the satisfaction of studying in an entirely new area, there were other unexpected sources of enjoyment in my new life. I realised, for the first time in over thirty years, that six hours' sleep a night was just not quite enough and how wonderful it was to have seven hours of sleep with no fear of a telephone call to attend the hospital. The joy of not having to spend at least an hour a day in my car, stuck in traffic, often running late. The pleasure of a stroll to a café to get a leisurely coffee. The satisfaction of having time to run, swim and cycle.

A very highly regarded colleague, who had had an extremely successful career as a clinician and academic, said he never thought about retirement, but about a transition to a new life. The concept of retirement can have negative connotations, associated with ageing, loss of skills and loss of identity. Sadly, there are colleagues who, for financial reasons, do not have the option of

stopping work. For those in regional or remote areas, stopping work may mean leaving their community without specialist expertise, making it difficult to leave. And I accept that there are colleagues who plan to 'drop in their tracks', so important is their career in their life.

But, if there is anything to be learned from our current unprecedented world disruption, it is that the future is an unknown place. As a group of professionals, we are intelligent and thoughtful people. Many will have ideas, not fully developed, of the things they still want to do in their lives. For those hovering uncertainly, unsure where to go late in their career, I would say to you: Be bold and consider taking on something entirely new.

You are smart and resourceful and will probably be successful. You will likely enjoy the new challenges.

Two years after leaving my O&G life, I have completed a Diploma in Urban Horticulture. I still have a need to keep busy with many projects. I have not done many of the things that I expected I would get done when I stopped full-time work. I miss my involvement with our trainees but enjoy seeing their careers flourish. It becomes more difficult to keep in touch with colleagues who are still working full time, but there is more time to nurture friendships. There is more study to undertake, gardens to tend, books to read, countries to visit (pandemics permitting). Definitely not retirement, but a whole new life.

Burnout and wellbeing in the COVID era

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Writing about burnout in medicine in 2020 has a different flavour than six months ago. Our lives have changed. The impact has been felt across the globe. The era of COVID is upon us and in a very short space of time, as medical professionals, we've had to dramatically change how we work.

Depending on where we are working, we've had to change our clinical practice, literally move our clinics, change to performing clinics via Telehealth, learn all about PPE (accessing PPE!), implementing safe operative practices often across multiple hospitals, study how we transition between our work and home environments and then also manage the impacts upon our home and family lives. This may have involved supervising children at home doing their schooling, supporting elderly parents in their homes or combining living and working in isolation.

For most of us, we've never before had to face such an unprecedented time. There was cause for significant anxiety, particularly in the first six–eight weeks where it was unclear if Australia was to head down the path that some of our international colleagues were facing in worst affected countries such as China, Italy, the UK and the US. Fortunately, with our excellent public health response and the Australian community's adherence to these early measures, we seem to have avoided the tsunami of patients with COVID and the associated morbidity and mortality and widespread impact on our health system and community that comes with that.

There are still many potential longer-term impacts on our community, our health system and us as healthcare professionals. There are many experienced mental health clinicians and services available to support our health workforce through the different phases that may come with the COVID pandemic. Work done in the first week of the COVID crisis by the Stanford group with multidisciplinary participants explored three key concerns: what healthcare professionals were most concerned about, what messaging and behaviours they needed from their leaders, and what other tangible sources of support they believed would be most helpful to them. The results are laid out as clearly as: Hear me, Protect me, Prepare, Support me, Care for me.[1] 'Minding our Healthcare Workers' is an excellent resource and, in particular, describes the different phases of the psychological responses and is available here: https://dhasq.org.au/coronavirus-covid-19-information. In addition, the British Psychological Society released a paper called 'The psychological needs of healthcare staff as a result of the Coronavirus pandemic,' which is an excellent resource that offers practical recommendations for how to respond at individual, management and organisational levels. It is available here: www.bps.org.uk/news-and-policy/psychological-needs-healthcare-staff-result-coronavirus-pandemic. The Pandemic Kindness Movement was created by clinicians across Australia, working together to support all health workers during the COVID-19 pandemic and the website of curated resources is available here: https://aci.health.nsw.gov.au/covid-19/kindness

We've seen many challenges with COVID but also opportunities – or as some are calling it, their 'COVID silver linings'. There have been incredible examples of collaboration and innovation in the medical and healthcare community and many say a positive sense of camaraderie as well as support from the community. Perhaps there are things we will want to retain on the far side of the pandemic.

Burnout in medicine

Burnout in medicine has been an escalating issue over the past several decades and has been increasingly described. Burnout, put simply, is a state of mental and physical exhaustion that can zap the joy out of your career, friendships and family interactions. It is very common for doctors,[12] and between 40–75% of O&Gs[2] or trainees[14] will be currently experiencing symptoms of burnout. Let's pause and reflect on that statistic. It is sobering. It's important that we recognise symptoms of burnout, in ourselves and our colleagues, so that we can intervene early before it progresses.

In the past several years, there has been more discussion of burnout and mental health in medicine than ever before. It was unbelievably powerful to have the RANZCOG President, Prof Steve Robson, come forward publicly in October 2018 and talk of his personal lived experience[3] and then to go on and become a strong advocate for doctor's health and wellbeing. Robson's invited Editorial on Burnout in 2019 was recently recognised as one of the most read in *ANZJOG*, showing the level of interest in this topic amongst our colleagues.[4]

There has fortunately been an evolution in the field to better understand that burnout is a syndrome conceptualised as resulting from chronic workplace stress that has not been successfully managed. In addition, in May 2019, WHO recognised burnout as a medical condition for the first time in the International Classification of Diseases. While the term burnout is clearly defined, it's focused on the individual rather than an occupational framework, when perhaps it should be viewed as a symptom of a deficient healthcare system. This is important because our response as a profession must involve addressing the system-wide and organisational issues that led to this increasing prevalence of clinician burnout. Two reports released in late 2019, one from the US and one from the UK, both address systemic and organisational approaches to addressing clinician burnout.[5,15] In Australia, we need to advocate, collaborate and mobilise as a profession to transform the healthcare system for the future.

Key dimensions of burnout

There are multiple formal definitions of burnout; however, the key features are that it is a work-related syndrome characterised by:

- Overwhelming exhaustion – feeling the physical and emotional response of stress and fatigued by the work environment
- Depersonalisation – feeling unemotional and distant towards one's work
- Cynicism – represents the interpersonal aspect of burnout and refers to negative, callous or excessively detached response to various aspects of the job, usually resulting in a negative reaction to people, loss of idealism and the dehumanisation of others
- Low professional efficacy – feelings of incompetence and a lack of achievement and productivity in work and represents the self-evaluation aspect of burnout[6]

Some of these symptoms may resonate with you, whether you have felt them before, often or even experiencing them now. If you are concerned, it's a good time to reflect and think about what may be causing these symptoms for you and whether you need to change something about your work, gather some support or seek help. Similarly, you may recognise colleagues when you read this piece; perspective and a compassionate approach are effective approaches in this situation.

Phases of burnout

There are several phases of burnout that a person may move through.

The physical symptoms can range from headaches, insomnia, palpitations, GI problems and teeth grinding through to more significant alcohol and/or substance use, loss of libido and progressively intrusive symptoms.

At a personal level, people may initially try to work harder, and this may result in emotional exhaustion, feeling drained and depleted, which can then make it harder to recover and find the motivation to go to work. Some people can become irritable, callous towards others, or lose compassion for their patients. There may be a change in the standard of their work or behaviour that might flag something is going on. At more advanced phases of burnout, cynicism, depersonalisation, procrastination and a profound sense of inner emptiness or exhaustion can be pervasive.[13]

There are, of course, many variations on this pattern. Fatigue may not be relieved by rest and family members or colleagues may start to notice behavioural changes including lack of enjoyment of usual activities or angry outbursts. There may be some cognitive impairment with short attention span and impact on memory. Some people may find they have a diminished sense of accomplishment, work no longer gives them a sense of fulfilment and they progressively start to withdraw from family and friends. Apathy and depression including suicidal ideation can occur, so it is important to be alert to these more advanced features of burnout.

It is important to note that many studies have found a correlation between burnout and rates of depression and they frequently co-exist, but not all doctors with symptoms of burnout have depression and vice versa. There is, however, a very strong relationship between burnout and suicidality. It is one of the reasons it is important to address burnout.

Factors driving burnout

There are usually several factors that may interact or build up and cause burnout. In fact, the numbers often help tell the burnout story: physicians who spend less than 20% of their week on a work activity they find meaningful are three times more likely to experience burnout compared to those who spend 20% or more on a favourite work effort.[5]

Sometimes these drivers build up and swirl together as a 'perfect storm' – sometimes they slowly accumulate over time, sometimes they peak with a busy period of ward service or because of a particularly difficult patient encounter at work or coinciding with a time when you are vulnerable in your personal life.

Factors driving burnout include:[8]

- Workload
- Flexibility and control over your work
- Efficiency
- Work-life integration
- Alignment of individual and organisational values
- Social support/community at work
- Sense of meaning derived from work

A lot of doctors in this modern era talk about their sense of loss of community at work and professional loneliness, the burden of administrative tasks and loss of autonomy and flexibility.

There is a risk of losing the humanity in healthcare, which is important because it is likely what drew most, or all, of us to medicine. The humanity restores and renews us through the contact we have with our patients, the compassionate care we give and the connection we get in return. Think back to when you started medical school. Reflect on what you have loved about the type of medicine you practice. Is that passion still there or is it diminished? What is getting in the way of you enjoying your job?

Consequences of clinician burnout

The high prevalence of burnout is a cause for concern because it can impact the quality and safety of patient care, professionalism, healthcare system performance and the clinician's own health.[9]

For doctors, this can lead to:

- Reduced empathy, productivity and presenteeism or absenteeism
- May consider a career change or leave the profession
- PTSD, suicidal ideation, increased substance use
- Relationship impact, divorce
- Impact on teamwork and impaired job satisfaction
- Physical: coronary heart disease, IDDM, MSK pains, fatigue, sleep disorders / insomnia, headaches, GI issues, reduced libido

Beyond burnout

Being able to recognise the signs of burnout in yourself or your colleagues is important. Having tactics to address them at a personal level is essential, as is starting to tackle them at a health system level as a profession.[11] As doctors, being able to have these discussions amongst ourselves and in our teams should be something we can do with ease and some expertise. Doctor's health and wellbeing should no longer be the elephant in the room. Keeping ourselves well throughout our careers, from day one of medical school through to retirement, with all the ups and downs that life throws at us, is something we can learn to do together.

If this article has raised issues for you, help is available at:

- Your own treating doctor is a good first contact
- Your Doctor's Health Service:

NSW and ACT:	02 9437 6552
NT and SA:	08 8366 0250
Qld:	07 3833 4352
Tas & Vic:	03 9280 8712
WA:	08 9321 3098
New Zealand:	0800 471 2654

Need crisis help right now?

- AMA Peer-to-Peer support service 1300 853 338 (this is anonymous and confidential, 8am–10pm, trained medical peer supporters, you do not have to be an AMA member)
- Lifeline on 13 11 14
- Beyond Blue on 1300 224 636

Websites that can provide further advice and resources:

- Doctors for Doctors: www.drs4drs.com.au
- Doctors' Health Advisory Service: www.dhas.org.au
- Beyond Blue: www.beyondblue.org.au
- The Australian Doctor's Health Network: www.adhn.org.au
- Pandemic Kindness Movement: www.aci.health.nsw.gov.au/covid-19/kindness

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Q&A

For the broader *O&G Magazine* readership, balanced answers to those curly-yet-common questions in obstetrics and gynaecology.

Q Your patient has been pushing for two-and-a-half hours with no progress. How do you assess the baby's position and decide whether an ongoing attempt at vaginal delivery is suitable?

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A

Determining the position of a baby's head in advanced second stage is a challenging task even in the most experienced hands. The correct determination of the head position, along with other features, will enable the best decisions to be made about further management.

The following are the steps to achieve this:

- Ensure that you have a clear idea of the pregnancy and the progress of labour. A longer and slower labour with significant back pain suggests the possibility of a persistent occiput posterior position.
- Ensure that you have a clear idea of how the woman has coped with vaginal examinations and discuss with her how she might best be able to manage the discomfort and pain of a vaginal examination. Have the woman empty her bladder if there is no catheter.
- Be clear about what analgesia the woman has had. A well-functioning epidural is sometimes required for an adequate vaginal examination in second stage. A pudendal block can be useful.
- Perform an abdominal examination noting any concavity in the abdominal contour above the symphysis; this suggests an occiput posterior position. Is the head engaged in the pelvis? if it is clearly, this then favours an occiput anterior position.
- Perform an ultrasound. If the spine can be clearly seen anteriorly, the baby's head is likely to be anterior. If your skills permit, try to identify the orbits of the fetus; if seen anteriorly, these will be a very clear confirmation of an occiput posterior position.
- Perform the actual vaginal examination, slowly and carefully.
  - » Feel for the Ischial spines and determine the level to which the bony part of the head has descended. If the head is very low (i.e. on view) sometimes this might not be necessary.
  - » Feel for the lambdoid suture of the occiput; is there moulding and how much? Remember, however, that a moulded set of parietal and frontal sutures can feel almost identical to an occipital lambdoid suture.
  - » Attempt to identify the anterior fontanelle; doing so helps to more securely confirm the position.
  - » Attempt to feel for the baby's ears if there are still difficulties in determining the position. This can be very useful when the saggital suture of the baby's head is in a transverse position or when there is significant caput and moulding.
- Get a second opinion if you have significant doubts about the position and descent.

RANZCOG Global Health

Dr Catherine Hamlin AC
(24 Jan 1924 – 18 March 2020)

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Dr Catherine Hamlin AC was born Elinor Catherine Nicholson on 24 January 1924. Catherine and her husband Reg are known throughout the world as founders of the Addis Ababa Fistula Hospital, Ethiopia, the second dedicated fistula hospital ever built.

Catherine grew up in Sydney and considered herself a 'tomboy', riding horses and climbing trees. During her time in university, she heard a Christian missionary speak and decided to work in low-resource countries. Catherine obtained her medical degree in 1946 and, two years later, was offered a position as resident at Crown Street Women's Hospital, Sydney. The medical superintendent at that time was Dr Reginald Hamlin. They were married in 1950. Over the next few years, they travelled and worked in England and Hong Kong and had a baby, Richard. In 1956, they decided to return to Sydney, but Reg was unable to obtain a job at Crown Street due to local politics. They decided to go to Adelaide to work but felt unsettled. While combing through medical journals in search of other employment, they came across an advertisement in the Lancet for 'gynaecologist wanted to set up school of midwifery in Princess Tsehai Memorial Hospital, Addis Ababa'. The contract was for three years. The Hamlins arrived in Ethiopia in 1959, and the rest, as they say, is history.

The Hamlins encountered many conditions uncommon in higher resource environments, one of them being the obstetric fistula (OF). Female genital tract fistulas occur for a number of reasons such as iatrogenic (gynaecological procedures), trauma and infections. The most common cause of OF worldwide, however, is prolonged obstructed neglected labour. Women with OF usually labour for days and deliver a stillborn baby. The fetal presenting part in the maternal pelvis for such prolonged periods of time causes pressure necrosis of tissues between the fetus and maternal pelvis. OF results in an abnormal communication between the lower urinary tract and vagina, and/or anorectum and vagina. Thus, the woman with a genito-urinary fistula leaks urine continuously through the vagina, and if she has an anorectal fistula, she will also leak faeces/flatus through the vagina.

The plight of the OF women, such as being ashamed of their condition, social abandonment and social stigmatisation, was noticed by the Hamlins. As in Australia today, female genital tract fistula was uncommon and so the Hamlins did not have much prior experience in the management of this condition.

Figure 1. Dr Catherine Hamlin AC with staff of the Addis Ababa Fistula Hospital.

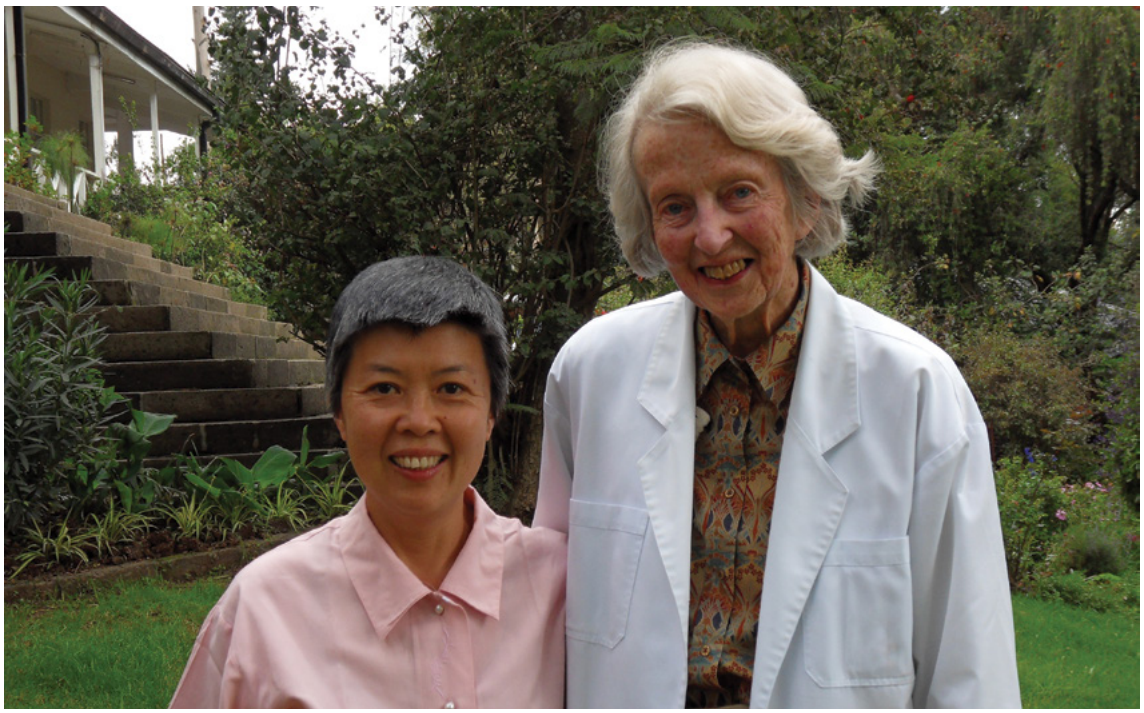

Figure 2. Prof Judith Goh AO and Dr Catherine Hamlin AC at the Addis Ababa Fistula Hospital grounds.

They read published literature on the management of OF and communicated with fistula surgeons around the world (there were not many). They attempted surgical repairs and had success. However, in low-resource areas, with a paucity of primary healthcare, emergency admission/surgeries were common and the elective cases such as fistula surgery were frequently cancelled. The Hamlins had a vision of a dedicated fistula hospital, where women could have elective surgery without being cancelled and also provide a place for the women to have medical conditions optimised, such as malnutrition, malaria.

After years of hard work, fundraising, obtaining land, building and war, the Addis Ababa Fistula Hospital opened on 24 May 1975. Since then, thousands of women have been treated and many doctors (including the authors) trained in fistula surgery. The Hamlins obviously stayed beyond their initial three-year contract. Catherine always believed her faith had a vital role in her life and that she was 'guided by God'. Even after Reg died in 1993, Catherine, having spent over 30 years in Ethiopia, decided to stay and continue with the work to fulfil their vision.

Anyone who has ever met Catherine would be aware of her selflessness and her compassion for her 'beloved patients'. She would hold their hands and hug them when they first arrived at the hospital. These women arrived very ashamed of their condition, with urine dripping into their clothing and plastic shoes and thinking they were the only person in the world with this condition. To try to explain the fistula, Catherine would hold up a sheet of paper, make a small hole in middle of the sheet, pour some water on the paper and the water would run out of the hole. She would then say that surgery can be done to close the hole.

Catherine also transformed the hospital grounds into an oasis for the women. She would bring back cuttings of bushes/flowers that she was fond of during her travels and have them planted in the hospital gardens. The hospital she co-founded provides a holistic approach to care – literacy classes, small group classes, physiotherapy etc. There is hostel type accommodation for women who are undergoing care to optimise their health prior to surgery.

Catherine lived on the hospital compound. She was much loved by the staff and patients. She was very hospitable, often having visitors for cups of tea and biscuits/cake. Many entertaining and wonderful stories of her life and experiences were shared over tea or a meal.

Many of the hospital assistants were fistula patients. Catherine was well aware that some women were deemed incurable, either with such significant childbirth injuries or ongoing post-fistula complications. In the later years, income generation projects/workshops were available for these women.

Catherine's hope was to prevent fistulas. As she became internationally renowned and resources became available, the Hamlin Midwifery College opened in 2007. The aim was to train midwives to recognise the abnormal progress in labour with early intervention or referral to prevent an obstructed labour and its consequences.

Catherine's life accomplished much for women's health around the world. Among her many awards, she received the Companion of the Order of Australia in 1995. She made fistula a topic to be discussed and not an obscure condition. Even in the mid-1990s when the authors commenced their fistula careers, fistula was not a popular topic, even in gynaecological circles. For those of us who have had the privilege of watching her operate, she was an excellent surgeon, and for those of us who had the honour of her tutelage, she was a wonderful teacher, mentor and an inspiration. She imparted upon the authors the love for her 'beloved patients.' For those of us who had come to know her, she was woman of faith, humility, integrity, dignity and principle. Catherine was a great advocate for women in medicine, women as surgeons and women with obstetric fistulas.

Case reports

No time to transfer: a rural emergency

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The following case occurred at the Cohuna District Hospital. We have a level 2 obstetric unit and refer more complex cases to Bendigo Base Hospital, 130km south over a rural road network. If on bypass (usually four days a month due to unavailability of a full theatre team) cases fitting our capability framework are referred to Echuca, 60km east via a rural highway.

Case description

K, 29 years old, A negative, G2P1 at 37 weeks gestation, presented as a fully dilated obstructed breech while the hospital was on bypass.

In her first pregnancy in 2017, K presented in early labour, also at 37 weeks when we were on bypass. 178cm tall with a BMI of 26, she had no medical problems. She was transferred to Echuca for management. Her slow progress resulted in an epidural and an oxytocin infusion. 12 hours later, she had a failed instrumental delivery and an emergency lower uterine segment caesarean (LUSC). The fetal head was impacted, and the uterus was friable. The LUSC took three hours, there was a tear into the lower segment and 1500ml blood loss. Resuscitation included blood, but mother and baby were transferred back to Cohuna the next day and recovered well.

This pregnancy was red flagged. The regional team booked K at Bendigo Base Hospital for an elective LUSC at 39 weeks gestation.

K had antenatal care in Cohuna with a planned review in Bendigo near 39 weeks. At 36 weeks, a scan found an engaged frank breech with a fundal placenta. Communication to the Base Hospital gave a revised plan: if she came into labour in Cohuna, refer her urgently, but if she was in established labour, we should deliver her in Cohuna by LUSC. As the baby was well grown and there were no maternal illnesses, the planned 39 week LUSC was reasonable.

K woke contracting and presented at Cohuna at 0130 for assessment. We were on bypass. K was fully dilated with the breech at spines. Given she had been in labour for one hour, and at 37 weeks, it seemed delivery was eminent. I discussed with the regional obstetrician and she concurred it was too dangerous to move her as we may be caught with an undeliverable aftercoming head in transit.

A theatre team was called. There was a GP obstetrician and two GPs to assist, but no anaesthetist. An anaesthetist not on call was contacted. He confirmed he was coming at 0215.

A decision pathway was set up consulting all staff. We used the planning process from PROMPT training to define roles and teams. K continued to contract but there was no fetal distress and no progression.

Plan A: Wait for the anaesthetist then perform emergency LUSC, but if fetal distress or impending delivery, proceed to plan B.

Plan B: The GP proceduralist to insert spinal and hand over to the anaesthetic nurse and proceed to LUSC. This plan was not a preferred option, but K was taken to theatre and everything set for an immediate LUSC. Theatre staff scrubbed and the rest of the team were called in. K lay on the theatre table from 0235 with two 16g IVs inserted and was preloaded with 600ml saline and given cefazolin 2g (GBS neg) and anti-reflux medication, plus 25mg IV pethidine for her pain. Tocolysis was discounted as there was no fetal distress. 4 units of O negative blood were available.

Plan C: Transfer by ambulance (had already been abandoned as most likely to have poor outcomes).

The anaesthetist arrived before a need for Plan B. Surgery commenced at 0320 under spinal. All layers were scarred and adherent. The bladder reflection

needed sharp dissection. The uterus was opened transversely using fingers to stretch the incision. The impacted breech was delivered, but the shoulders were held tightly in the muscular upper segment in a constriction ring. The shoulders and arms delivered with Loveset's manoeuvre, but the head could not be delivered with direct traction, extending the fetus over the uterus or the Mauriceau-Smellie-Veit manoeuvre. A hand under the fetal head with external pressure on the uterus allowed delivery of the head. Baby was stunned but rapidly recovered. Arterial cord lactate was 2.5, Apgars were 6, 8 and 9, four minutes CAP were need. The placenta delivered spontaneously as oxytocin 10u was given IV.

The uterine incision tore into the left side of the uterus with brisk arterial bleeding. The bleeding area was packed while the original incision was closed with a 1/0 caprosyn suture. The left side of the wound was then lifted using the first suture end and the 4cm long extension wound identified. This was sewn through and through with traction maintained on the suture line, tying it off once bleeding controlled. The rest of closure was routine. Blood loss was 600ml. Pre-op Hb was 122. Next day Hb was 114. 3L of normal saline was given, two post-op to keep bladder flushed. The urine drained by the pre-op catheter was clear, but post-op was heavily blood stained. This cleared over 24 hours. The regional obstetrician suggested a cystogram. There was no leakage outside of the bladder on cystogram 30 hours post-op, so catheter was removed.

A Keilhauer test showed a 29ml fetal-maternal haemorrhage, fetal blood group was A negative. Fetal Hb was 13. Neonatal blood sugar was 1.6 at two hours and baby had a single dose of glucose gel and an early formula feed. Sugars remained in range and the baby was nursed in a humidicrib for four hours. Care from there was normal. Mother and baby went home on day 4.

Discussion points for comment

1. We identified this as a high-risk case antenatally with an appropriate delivery plan at a base hospital, but no plan to care for this lady close to appropriate care once she was at term. Were her risks elevated by previous 37 week labour, breech and PH of obstruction? Should term women be offered accommodation close to the planned site of care? Expectant mother more than 50k from the hospital providing care are at increased risk of roadside delivery and adverse outcomes.[1] Guidelines[2] suggest elective LUSC delivery at 39 weeks is appropriate but these guidelines do not take into account distance from care or how emergency delivery before 39 weeks will be dealt with locally.
2. The constriction ring found at LUSC was not appreciated prior to surgery. K had pain and a prominent fundal bulge with full dilation and failure of descent of the presenting part; this is a classical but forgotten sign of obstructed breech.[2,3,4]
3. Training in managing a constriction ring isn't easy to find.[5] Options include a planned classical LUSC (a fundal placenta made this unattractive) or a T incision. The manual disimpaction I used (similar to the technique for a retained placenta with a hand deep in uterus sliding under the head and pressure applied externally to the internal hand rather than the head) is not previously described. This was successful but caused a traumatic placental separation as indicated by the 29ml fetal-maternal transfusion.
4. Management of the lateral wall tear by traction on the primary closure suture identified the extent of the tear and allowed successful control of bleeding. If I had been unsuccessful, my options would have included packing and transferring to the base hospital by ambulance or a sub-total hysterectomy. Remember this was at 0330 in Cohuna.
5. Management of traumatic macroscopic haematuria was by leaving a catheter in situ until cystogram performed but without cystoscopy. What is the standard?

Conclusion

This case illustrates issues facing rural GPs in planning and implementing care for high-risk patients with limited resources. There are issues in dealing with unexpected complexities that I thought might provoke others to discuss how they would manage this in their region.

Commentary from Dr Jared Watts

This case demonstrates the difficult and challenging work rural GP obstetricians often face. Even with the best planning, often high-risk cases can occur in these limited resource settings. There is a concern that this may occur more often now as smaller rural maternity units are closed, but this does have to be balanced with being able to adequately staff all country units. Dr Barker and his team excelled in calling in all available resources and personnel, considering all available options and they had previously trained as a team with a PROMPT course. All these activities assisted in leading to the final excellent outcome for the patient who had a very complicated delivery.

Often in these settings, we need to return to the basics, as this team did. Packing has been demonstrated to achieve haemostasis both in the short term while calling for assistance or it can be used while transferring patients to another unit. It is tempting to transfer undelivered patients quickly in such situations to higher resource centres, but this can place the patient and staff at even higher risk if the patient delivers outside of a hospital setting. Bandl's rings are reported to be rare but are potentially increasing and therefore research and training modules needs to be developed regarding the approach a surgeon should take in such situations. Interestingly, noting how rarely surgeons encounter Bandl's rings, Gupta et al have developed a model from simple home supplies they use for training in such situations.[6]

This case also highlights another challenge that is often raised to CCDOG Committee. Many tertiary and larger regional hospitals kindly take GP obstetricians for upskilling, in particular for caesarean sections. This is a fantastic opportunity for rural and remote GPs to maintain and further develop their skills. Often, however, they report that if a case has some complication such as a placenta praevia, twins or it is a patient's fourth or fifth caesarean, they are asked to stand aside as 'you won't do this type of delivery in the country.' This is true, we try and relocate all moderate to high-risk patients to larger units prior to delivery, but as this case demonstrates, this sometimes does not happen as patients may labour early or the complication is not diagnosed until they are in labour. The GP obstetrician is then often left managing this patient on their own, with extremely limited resources and local supports.

So next time you have a GP upskilling with you, we urge you to get them involved in these more difficult cases. Teach them about what to do with a placenta praevia, how to get that back down, transverse baby out at caesarean section or how to get into an abdomen of a woman with five previous laparotomies safely and quickly. At our unit, we get our GP obstetricians to also assist with abdominal hysterectomies, just in case they need these skills one day in a remote area. By teaching a GP obstetrician these skills, there is a high chance that one day, thanks to your teaching, a life may be saved in a rural or remote area.

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Appendiceal cancer diagnosed in pregnancy

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Case description

A 34-year-old woman, gravida 4, para 3, presented to a tertiary centre at 26 weeks gestation with right-sided abdominal pain and constipation. She had been managed for a pelvic infection 18 months prior to presentation due to both chlamydia and gonococcus and she also volunteered a past history of irritable bowel syndrome. She was a current smoker. An abdominal ultrasound was performed, which showed a complex collection in the right lumbar region of the abdomen. An MRI on the same day demonstrated a retrocaecal loculated collection measuring approximately 61 x 73 x 50mm with surrounding fat stranding, reported to be consistent with appendicitis and a peri-appendiceal complex collection. She had a mildly elevated white cell count (10.8x109/L) and a raised C-reactive protein (CRP) of 150 mg/L.

Surgical consultation was undertaken, and the decision made for laparotomy that night to further evaluate the findings. At the time of the operation, the appendix could not be clearly defined. An abscess at the lateral aspect of the caecal pole was washed out with view to performing an interval appendicectomy postpartum. A drain was inserted, and removed four days post-operatively. Histopathology of the mesoappendix demonstrated acute inflammatory changes and abscess formation. Culture of the purulent fluid drained grew *Escherichia coli* and mixed anaerobic flora. She recovered well post-operatively and was managed with intravenous ceftriaxone and metronidazole. Her pain improved, and she was discharged home six days post-operatively with oral antibiotics.

The patient re-presented multiple times post-operatively (between 28 to 34 weeks gestation) with purulent discharge and worsening pain in the vicinity of the previous abdominal drain site and in the right flank, despite ongoing oral antibiotics (amoxicillin and clavulanic acid). A further MRI at 29 weeks gestation demonstrated a fluid-filled tract from the right iliac fossa to the right lateral abdominal wall, suspected to be a colo-cutaneous fistula. A percutaneous drain was placed under interventional radiology guidance and remained in situ until after delivery. Due to concerns regarding the fetal implications of ongoing episodes of infection, a maternal-fetal medicine consultation was obtained to assess for any ultrasound evidence

of central nervous system changes. No abnormalities were discovered. The patient was discharged home again with twice-weekly outpatient follow-up appointments for clinical review and review of inflammatory markers.

Due to concerns raised by a rising CRP, and the fact that the patient was now at 36 weeks, induction of labour with Prostaglandin gel was planned. She proceeded to an uncomplicated normal vaginal delivery of a well-grown infant (3047g). The baby was well at birth, with Apgar scores of 8 at one minute and 9 at five minutes. The baby was admitted to the neonatal intensive care unit for five days post-delivery due to respiratory distress requiring CPAP, thought to be due to transient tachypnoea of the newborn. The baby was given intravenous penicillin and gentamicin due to concerns for potential sepsis, although all blood cultures remained negative.

One week postpartum, the patient reported ongoing significant pain. CT scan demonstrated a persistent multiloculated retrocaecal collection with a thick enhancing rim extending superiorly to the inferior pole of the right kidney, as well as an abdominal wall collection which had increased in size since previous imaging. The patient was taken to theatre for a laparoscopic appendicectomy, but due to the operative findings of anatomical distortion and severe inflammatory adhesions, this was converted to a laparoscopically assisted right hemi-colectomy. Histopathology subsequently demonstrated a 7cm appendiceal mucinous adenocarcinoma (pT4a pN0), moderately differentiated with foci of lymphatic space invasion. 19 lymph nodes were sampled with no evidence of tumour.

Adjuvant chemotherapy with XELOX (oxaliplatin and capecitabine) was commenced, and at the time of writing, the patient is undergoing her seventh cycle of this regime. Dose reductions of the chemotherapy were required due to nausea, vomiting and diarrhoea. She is planned to receive six months of chemotherapy, with repeat imaging and potential laparoscopic surveillance after completion given her high-risk disease.

Discussion

Tumours of the appendix presenting in pregnancy are rare; there has only been one other case describing mucinous adenocarcinoma of the appendix, and three reports of carcinoid tumours of the appendix diagnosed during pregnancy. In the one other case of mucinous adenocarcinoma of the appendix in pregnancy,[1] this occurred in a 36-year-old woman who was 18 weeks pregnant, with a finding of a 4cm mass following laparoscopic appendicectomy.

This patient subsequently decided to terminate the pregnancy and proceeded to complete debulking surgery with right colectomy and intraperitoneal heated chemotherapy. After 10 months of follow-up, the authors described a satisfactory outcome. Three other case reports have been published describing carcinoid tumours of the appendix diagnosed during pregnancy,[2-4] although these have a very different prognosis to adenocarcinomas.

Diagnosis of the tumour in this case was complicated by a preterm pregnancy and difficulties operating in the presence of a gravid uterus, which necessitates consideration of the operative technique and positioning of the mother with regards to compression of the inferior vena cava. Planned interval appendicectomy is a recognised treatment for perforated appendicitis complicated by abscess and may be safer in pregnancy than primary definitive surgery. In this case, the perforation was almost certainly due to the tumour, resulting in tumour stage T4a at the index presentation and mandating adjuvant chemotherapy.

Due to her age and fitness, this patient was a good candidate for adjuvant chemotherapy, although the evidence for this is limited as this is generally extrapolated from large colorectal cancer trials, with poor inclusion of appendiceal mucinous adenocarcinomas. A large retrospective database published in 2016[5] of more than 11,000 patients with Stage 1–3 adenocarcinomas of the appendix demonstrated a five-year overall survival of 53.6% for mucinous adenocarcinomas of the appendix. There was improved overall survival observed for patients who received systemic chemotherapy (Hazard Ratio 0.79,)[5] although chemotherapy regimens varied.

Conclusion

Appendiceal tumours are rare, and present additional challenges when arising in pregnancy due to the difficulties in diagnosis and management.

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RANZCOG
Women's Health Foundation

Research and Travel

Scholarships, Grants and Fellowships

Commencing 2021

NOW OPEN

The RANZCOG Women's Health Foundation

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) supports research in the fields of obstetrics, gynaecology, women's health and the reproductive sciences through the awarding of various scholarships, fellowships and grants each year by the RANZCOG Women's Health Foundation.

The RANZCOG Women's Health Foundation proudly supports promising Fellows, Trainees, clinical researchers and scientists undertaking high quality, innovative research and research training at an early stage in their career.

The RANZCOG Women's Health Foundation is pleased to announce that the following Scholarships, Fellowships and Grants will be available for application in 2020 and commencement in 2021.

Application Process

Applications must be submitted to the RANZCOG Women's Health Foundation by **30 June 2020**.

The Scholarship Application Pack and application forms are available on the Foundation website:
www.ranzcog.edu.au/foundation

For further information, contact:
P: 03 9412 2993
E: foundation@ranzcog.edu.au

Research Awards

Glyn White Research Fellowship
$30,000/year for two years

Mary Elizabeth Courier Research Scholarship
$40,000/year for one, two or three years

Norman Beischer Clinical Research Scholarship
$30,000/year for two years

UGSA Research Scholarship
Up to $40,000 in scholarship funding available each year with some flexibility depending on the number and nature of applications received

RANZCOG NSW Regional Committee Trainee/Fellow Research Grants
Trainees: $10,000 each (two awards)
Fellows: $10,000 each (two awards)

Travel Awards

Beresford Buttery Travel Grant: $5,000

Brown Craig Travel Fellowship: $5,000 (two awards)

Luke Proposch Travel Fellowship: $4,000

RANZCOG NSW Regional Committee Travel Scholarships:
$10,000 each (two awards) or $20,000 (one award)

All amounts in AUD

RANZCOG Women's Health Foundation

Scholarships providing opportunity for growth

Showcasing urogynaecology to the world

Thanks to a RANZCOG Women's Health Foundation scholarship, FRANZCOG Dr Jerome Melon has been able to take his work onto the world stage.

A third year urogynaecology fellow currently undertaking his final year of subspecialty training at McGill University in Montreal, Canada, Dr Melon was awarded the Brown Craig Travelling Fellowship.

This scholarship helped Dr Melon travel to the US in September last year and present his research at the American Urogynecologic Society/International Urogynaecological Association Joint Scientific Meeting in Nashville, Tennessee, the largest meeting in urogynaecology, held only every three years.

The Brown Craig Travelling Fellowship

The Brown Craig Travelling Fellowship, established 1964, helps applicants present a scientific paper at a RANZCOG Annual Scientific Meeting or another relevant interstate or international scientific meeting, or to visit any country outside Australia or New Zealand for the purpose of making a particular study of any scientific, research or clinical subject relating to the practice of obstetrics or gynaecology. Learn more about the RANZCOG Women's Health Foundation at https://ranzcog.edu.au/womens-health/foundation.

A positive step

At the meeting, Dr Melon presented two of his research projects, including: a cohort study looking at the medium-term clinical efficacy and safety of two types of single incision mid-urethral slings compared with transobturator controls; the other study investigating the association between a reduction in levator hiatal parameters on transperineal ultrasound and symptoms and bother of obstructed defaecation and anismus.

The abstracts for both podium presentations have since been published in the *Female Pelvic Medicine and Reconstructive Surgery Journal* (https://journals.lww.com/jpelvicsurgery/pages/default.aspx).

'Showcasing my research on the international stage was a positive step forward for me and has permitted me the opportunities to network with clinicians working on similar projects internationally,' Dr Melon says.

Dr Jerome Melon.

'Out of this experience I have since been collaborating with a physiotherapist who is currently researching the posterior vaginal compartment and obstructed defaecation. Both of us are now involved and collaborating with each other's research.

'Likewise, through the experience of presenting at this international meeting, I met two other urogynaecology fellows – in the USA and Netherlands – and we are collaborating together and writing a review article on sacrohysteropexy.

'All in all the experience of attending this meeting, presenting my research on the international stage, and the opportunities to meet like-minded clinicians in the field with which to ongoingly collaborate has been extremely enjoyable, rewarding, and invaluable for my future career.'

Addressing health inequities to save lives

Andre Khoury
Head of Communications and Public Affairs

For Diplomate Dr Alyce Wilson, the passion she has for health equity and advocacy can be encapsulated in two words: saving lives.

'We cannot improve health outcomes without addressing health inequities. Addressing the social determinants of health is key,' Dr Wilson says.

'As doctors, I think we have a responsibility to advocate for poor and marginalised groups who lack political, social or economic power. We need to advocate for social, economic, educational and political systemic changes that prevent disease and promote and protect health.

'However, in doing so, we need to be reflective and cautious and not assume we know or understand the needs and priorities of these groups and ideally should aim for any advocacy efforts to be collective and collaborative.'

It is this passion that has seen Dr Wilson recently awarded a Stillbirth CRE top-up scholarship, worth $9000.

Stillbirth CRE PhD top-up scholarships

Through a competitive process, the Stillbirth CRE (www.stillbirthcre.org.au) offers top-up scholarships to eligible PhD students receiving external competitive PhD scholarships. These top-up scholarships are designed to support exceptional PhD candidates whose projects align with the CRE's priority areas and make a meaningful contribution to the CRE's program of work.

Dr Wilson's work is looking at quality pregnancy, childbirth and newborn health services in Papua New Guinea (PNG). 'Quality care during pregnancy and childbirth saves lives,' Dr Wilson says. 'Worldwide, it is estimated that improvements in the quality of maternal healthcare could prevent as many as 531,000 stillbirths each year. PNG's high rates of stillbirth, up to 30 per 1000 live births, demands the identification of new and effective ways to end preventable stillbirths.

'Low-income countries like PNG face unique challenges in providing quality care during pregnancy and childbirth. There is a need for research in these resource-constrained settings to determine how to improve the provision of quality care to avoid preventable stillbirths.'

The study is using a mix of quantitative and qualitative tools – interviews, focus groups, clinical observations, facility audits and reviews of clinical records – to evaluate the current quality of maternal and newborn care provided in five health facilities in East New Britain, PNG.

Figure 1. The research team reviewing medical records and conducting facility audits as part of the quality care assessment. (L to R) Priscah Hezeri, Primrose Homiehombo, Kerryanne Tokmun, Alyce Wilson, Rose Suruka, Pele Melepia.

Figure 2. The research team on the road, visiting facilities. (L to R) Duk Duk Kabiu, Ioni Pidian, Stenard Hiasihri, Alyce Wilson, Pele Melepia.

Using a Partnership Defined Quality approach, Dr Wilson is working with local health services, clinicians and community members to explore quality, and mutually design, implement, monitor and evaluate quality improvement activities. The findings will be scalable, sustainable and highly relevant to reducing preventable stillbirth across PNG and other low-resource settings where similar challenges and gaps exist in healthcare services.

Scholarship to make a difference

'I was thrilled to hear that I had been awarded a Stillbirth CRE top-up scholarship,' Dr Wilson says. 'The scholarship will contribute towards the costs needed for study trips to PNG. These trips are essential to maintain stakeholder relationships, support the local research team in Kokopo with project coordination and provision of training in appropriate research standards and approaches and conduct workshops to discuss study findings with obstetric, midwifery and paediatric colleagues in East New Britain.'

Further funding is being sought to conduct the next phase of the study, which involves working with local clinicians to develop and implement culturally appropriate interventions to improve quality of maternal and newborn care in order to reduce preventable stillbirths.

From a young age, the passion grew

Wanting to make a difference in people's lives can be traced back to when Dr Wilson was 12. It is then, she says, through family hardship she was inspired to become a doctor.

'My family has a strong history of cancer and a number of family members carry the BRCA2 gene – a gene mutation that strongly increases the risk of breast, ovarian and other cancers,' she says. 'My mum was diagnosed with breast cancer when I was young and I think it was seeing her go through her surgeries, chemotherapy and how the doctors cared for her (particularly doctors that recognised she was more than her cancer – a mother, sister, aunty, friend – a person, in fact) that inspired me to become a doctor.'

Her passion for working in maternal and newborn health came about as she undertook her DRANZCOG and Master of Public Health, and from working abroad in India and Samoa.

'I'm driven by the poor health outcomes experienced by women and newborns in low- and middle-income countries like PNG,' Dr Wilson says. 'PNG has one of the highest maternal mortality ratios for the Asia Pacific region. The death of babies in the first 28 days of life is also high at 23.5 per 1000 live births. The real rates are probably higher, as about half of women give birth out of the health facilities and so are not counted. Only 55% of women have four or more antenatal care visits.

'The majority of these maternal and newborn deaths and stillbirths are preventable, and through implementation research we can find effective interventions and identify policy changes needed to save lives.'

RANZCOG President Dr Vijay Roach said, 'Dr Wilson's genuine commitment to women of the Pacific, combined with her extraordinary academic ability, makes her a worthy recipient of the Stillbirth CRE scholarship. She exemplifies the best qualities of leadership and advocacy, attributes that are critical to the progression of women's healthcare in PNG.'

Prof Newnham: Senior Australian of the Year

Maha Sidaoui

It is the subtext of learning that cuts through and opens corridors to what is real, essential and hidden from plain sight.

As a young medical student, Prof John Newnham became conscious of—and then fascinated by—the hidden world of life before birth, which he referred to as an 'undiscovered continent'. In a myriad of ways, he has spent his professional life exploring that continent. Early on, he set about fulfilling a clear career ambition: how to safely lower the rate of preterm birth. His research led to world firsts and earnt for him, amongst other accolades, the title of Senior Australian of the Year 2020.

John Newnham is recognised as one of the world's leading authorities in the prevention of preterm birth. A Professor of Obstetrics, he developed a pioneering initiative that resulted in an 8% reduction of premature births in Western Australia (WA) delivered through the Women & Infants Research Foundation, he founded the Australian Preterm Birth Prevention Alliance (the first national program of its kind in the world), and in 1989, he established the pioneering Raine Study, the world's first and most enduring pregnancy-focused lifetime cohort project.

Dr Roberto Romero (editor-in-chief of the American Journal of Obstetrics and Gynecology) summed up John's contributions when he said, 'An intellectual leader of modern obstetrics, Prof John Newnham has made pioneering research contributions which have changed the practice of medicine and improved the health of women and infants. He is an exceptional physician-scientist, teacher, and ambassador for our discipline.'

John spoke to me via phone from his office at Perth's King Edward Memorial Hospital in January, not long before he received his Senior Australian of the Year award, and just as the World Health Organization was sounding the alarm over Wuhan's Coronavirus epidemic. We talked about the journey from the moment he heard about his nomination to the months leading up to the award night in Canberra, along with his ground-breaking work, becoming a pioneer and advocate for change, and how he shifted the entire world's perception of preterm babies.

During our conversation, I admitted that I was one of the many who thought that preterm births were unavoidable and generally had a safe outcome.

John replied, 'Our profession has done this: we often said that it would be okay, and told you babies will be fine. Not knowing now there is data to show it has ramifications on school children and their behaviours.' Clearly there is much re-education that needs to take place.

The Senior Australian of the Year profile, he hopes, will help to get this message across.

So, the morning after the January 25 awards ceremony in the Village Centre at the National Arboretum Canberra, John was on national breakfast television and radio. Even though he'd had only a few hours' sleep, the re-education of Australia had begun.

'Babies are not mature until 39 weeks.' As John explained to me, 'We have been misled by our predecessors into thinking that term is 37 weeks. It certainly is not. Preterm birth is the single greatest cause of death and disability in children up to five years of age in the developed world and a major cause of lifelong disability. Eight per cent of Australians are born preterm. And in Indigenous Australians, that rate is almost double.

'The gestational age has profound implications on these children. Many will go on to live a normal life, but for many...in the newborn period, it is death, respiratory disease, cerebral haemorrhage, necrosis of the bowel, infections, and prolonged stay in an intensive care environment. In childhood, it is cerebral palsy, chronic lung disease, deafness, blindness, learning difficulties and behavioural problems. In adulthood, it is metabolic syndrome, diabetes and heart disease.'

I asked John, 'How is premature delivery preventable?'

'Every year worldwide, 15 million babies are born preterm, and it is the biggest cause of death of children under five. We want to make sure no babies are delivered before 39 weeks of pregnancy, without a medical reason. Through research, we have learnt that some of the very early preterm babies can be prevented by us doing certain ultrasound measurements as part of the normal mid-pregnancy scan. So, we are making changes to the way we use ultrasound during mid-pregnancy variants. A mid-pregnancy scan would include a measurement of the length of the cervix. We have simple treatments

that we can use to reduce the risks of babies delivering early if we find an abnormality on those scans. The most important thing a woman can know is the length of her cervix come mid-pregnancy.

'A short cervix at 16-24 weeks is a predictor for preterm birth. Identifying this at the standard 19-week ultrasound means the mother can immediately start progesterone, a treatment that will take half of those at risk to full term,' John said.

'I haven't seen an ultrasound report from a mid-pregnancy scan in WA in years without the cervix length included. This simple measurement has had a profound and immediate effect on outcomes in WA. After 18 months, the rate of preterm birth was lowered by almost 8 per cent. Most of the reduction was seen in the late preterm birth group (greater than 34 weeks gestation), with a matching rise in deliveries after 39 weeks.

'Programs are now being rolled out across Australia. There is no road map to follow, but we should be proud of the fact that no other country has ever lowered its preterm birth before.'

There was a moment, immediately after the Australia Day ceremony, when a reporter asked, 'Will you use this award to propel your message?' John raised an eyebrow and said, 'Of course. The goal is to get rid of preterm birth, to do everything we can to make sure that every Australian baby is born healthy at full term and can achieve that child's potential.'

Later, he tells me, 'There is nothing more valuable that I can do with my time: to study a cohort of people from early fetal life, through to the rest of their life span.'

But then his modesty gets the better of him—the Australian of the Year award is humbling. John doesn't believe he has worked any harder than his colleagues. 'I'm not made of this stuff. I was taught not to stand out, to be one of the boys. Even on the footy field, if you happened to kick a few extra goals that day, the boys would bring you back to earth. I have asked myself, why me?'

John tells me he sacrificed a lot, missing celebrations and important events to attend to his work. 'I've been an OB for decades, my wife had to suffer with me not being at home and she has done a wonderful job raising our three children. The highs are very high, the lows are very low, but it is an extremely rewarding job.'

On one level, we are driven by the unconsciousness to get through, at times it can become a default setting, what some refer to as the rat race. John's gnawing sense of intrigue for uncharted territory broke through and brought him to a world stage in his field. 'I had no intention of becoming an O&G. I was 22, in my fifth year of medical school (back then it was a six-year course) when I was going through one of the textbooks before a lecture, and noticed something about the fetuses—back then they were referred to as a passenger and the mother as the power. I could see that each fetus was different. All the faces were different sizes. Some were fat, some small, some trim. I asked what it meant and what implication this would have on the baby.' This was long before live ultrasounds were available, and John was told that his job would be to deliver a baby, and the day it was born was its birthday. That was when John became aware that unborn fetuses were an 'undiscovered continent'.

Prof John Newnham receives his Senior Australian of the Year award.

'I don't run with the pack and I always wanted to be an explorer,' John said. 'I've been an OB for 40 years, the magic never goes, and the great pleasure for families as they build their family and have their children is one of the most wonderful things in life. But it's not wonderful for everybody and it's not safe for everybody and the biggest problem in Australia is the risk of being born preterm. Every day, I see women delivering preterm babies and I know what the future holds for many of these children. Now we're really doing something about it and Australia has a terrific healthcare system and we are in a very good position to lead the world in this field.'

With every answer, with every insight shared, he expresses empathy for those who may have suffered and what they may have endured. It is this compassion for others that continues to be his driving force. As part of a video project recorded last year, John says, 'I apologised to the parents for not having been able to prevent the early birth of their child. It inspired me to find a way to prevent this heartache and pain for the parents and suffering for their child.' Not surprisingly, John ultimately began to think about how to predict those catastrophic early deliveries.

'In 2013, I was in the operating room of our theatre—it was late at night and I was working with my colleague Scott White who has an office with me right next door. A woman came in, her water was broken and the baby was lying sideways. I knew we would have to carry out an invasive caesarean section to safely deliver this baby.' The patient was 26 weeks pregnant (24 weeks in utero is considered the edge of viability) so the fetus's organs were present but not yet responsible for sustaining life. Her child would need nearly four months of protected development in the womb.

'We handed the newborn baby of 600gm to the paediatrician and I knew what lay ahead for the child and for the family, and it was going to be months in the intensive care unit.' The infant would spend the next few months in the hospital in a clear plastic incubator, dwarfed by large machines and barely visible among the tangle of wires and plastic tubes. And every day, the parents would strain to reach and gently stroke a leg or an arm via the two side ports, the only means of providing vital human contact.

'The months ahead can be frightening and very lonely for the parents and I thought to myself, how can we prevent this? This woman would have had her mid-pregnancy scan six week ago. How can we possibly leave this unattended? How can we possibly continue to let a woman go past 20 weeks of pregnancy without doing all we can to make sure that she is not going to have a preterm birth? So, in the corridor outside that theatre in 2013, I decided we would roll out the program across the state: The Whole Nine Months.'

John and I meet again, eight weeks later, when we have moved from an epidemic to a pandemic. We are now living in a different world, or as John puts it, 'We have retreated back to the borders.' We talk about the year to come and John says, 'My whole whiteboard was covered and within 72 hours, the whole thing had folded. Every conference, every group and every function.' I ask, 'How will you get your message across?'

'There are many ways to get a message across and alternative ways of communicating. We just need to find another way of doing it.' John remembers The Whole Nine Months program. 'In 2014, I thought I would have to raise money for television advertisements. I was educated very quickly that social media was the way to go, and the number of hits we have got across various platforms is wonderful.'

After a moment's pause, John says, 'I think good things will come out of this. I don't think things will go back to the way they were. The technology has set up everyone and we have the means to deal with it. There has been two weeks of massive change and in the hospital, we're preparing for the onslaught.' Right now, John's main concern is how to reach pregnant women who are at their most vulnerable during this COVID-19 crisis.

Over the decades, John has not been averse to change, and I ask how caring for women has changed during those years.

He reflects on changes he has seen at King Edward Memorial Hospital, Perth's main maternity hospital for over 100 years and where he has worked for most of his life. 'The population has changed. It is now a lot more multiracial. We're also seeing women who are older and who are living with heart disease, severe diabetes, cystic fibrosis, and so we have to know more. When I was studying OBs in university, it wasn't as complicated as it is now. It used to end with the placenta being delivered. The aim is no longer just to deliver the baby. Now it is more demanding, multidisciplinary, you have to work in teams and it's much more gratifying. It's what happens before the birth. Across the country, there are many OBs, GPs and midwives who are very committed to making a huge difference.'

John has only gratitude and praise for the teams he has worked with over the years, and tells me it was the one sticking point when the ABC asked him (and every other nominee) to make a pre-recorded message to be played before the winners were announced. 'I've worked with a team for decades so I couldn't talk about the work as if it was just me. But they kept asking me to say I instead of we when referring to the work. They said, "It's not about the teams, it's about you". We finally came to an agreement when I said that I would say "My team".'

All of John's attempts were met with encouraging feedback, but they kept asking him to repeat what he had just said. Something wasn't working, but it was only after many attempts that the penny dropped. 'I went back to the days when I sat for my O&G oral exams. I realised that I was being tested and as soon as I made that connection, I thought "Okay, I know what I have to do", and I felt inspired. Then they said, "Now tell a funny story". So I said, "If I was running for Prime Minister, I would make it a priority for every woman to know the length of their cervix".'

'Did they laugh?'

'They didn't think that was very funny.'

John eventually got through the day and his message can be found here: www.abc.net.au/7.30/professor-john-newnham,-wa-senior-australian-of/11867966

There is a journey that you travel on when you're nominated for Senior Australian of the year. On one level, it's an emotional journey of several months, as well as the eventual physical journey to the National Arboretum in Canberra, which features 700 acres of world-recovered seed from trees that are re-fertilised, nourished and then replanted. One of the Arboretum's well-known features is the beautifully curved Gift of Life Garden that references the cycle of life and the constant underlying rhythm of a heartbeat. John says that while he was walking through the garden, he was mentally preparing himself for what it would mean if he was to become Senior Australian of the Year.

I ask John, 'What does it mean to be an Australian of the Year?'

'As an everyday Australian, you can be anything you want, but we are joined together by certain principals, values and responsibilities. When you are put in a leadership role, that's when you have to step up. I now have a responsibility.'

Everyone who has achieved significant goals in their work, family or personal life has learned how to put setbacks in perspective in order to overcome challenges that life throws at them. John tells me, 'When there are challenges around, I put my head down, I work hard, stay productive, and be kind to as many people as I can. I believe that good fortune will then find you. And that's exactly what has happened in my life.'

After a pause, he has another humbling moment and says, 'You know, on Tuesday night, I still had to put the bins out.'

College Statements update March 2020

Revised College Statements

The following College statements were approved by RANZCOG Council and Board in March 2020:

Instrumental vaginal birth (C-Obs 16)

- Updated references
- New recommendation regarding administration of antibiotics following an instrumental birth

Management of Hepatitis C in pregnancy (C-Obs 51)

- Updated references

Pregnancy and smoking (C-Obs 53)

- Rewrite
- Formerly Women and smoking
- Recommendations to align with Safer Baby Bundle & Stillbirth CRE
- Additional support programs listed
- Additional information on indigenous population

Exercise during pregnancy (C-Obs 62)

- Updated references

Vaginal screening after hysterectomy (C-Gyn 8)

- Rewrite

Cervical cancer screening in Australia and New Zealand (C-Gyn 19)

- Rewrite
- Align to National Guidelines
- New guidance includes New Zealand

Uterine artery embolisation (C-Gyn 23)

- Rewrite

Consent and provision of information to patients in Australia (C-Gen 2a)

- Updated references
- Align to MBA regulations
- Additional section on informed consent
- Additional section on consent for teaching and supervising students

Driving after abdominal surgery including caesarean section (C-Gen 21)

- Rewrite

A full list of College Statements can be viewed at www.ranzcog.edu.au/Statements-Guidelines.

RANZCOG Patient Information

There are 41 RANZCOG Patient Information Pamphlets, including the new Pregnancy and Childbirth pack of 18 pamphlets, now available. All of these products can be viewed and ordered from: www.ranzcog.edu.au/Womens-Health/Patient-Information-Guides/Patient-Information-Pamphlets.

Prof Yee Leung
Chair
RANZCOG Women's Health Committee

Obituary

Dr Jennifer Wilson
1934–2019

Dr Jennifer (Jenny) Wilson died on the 20th December 2019, aged 85. Jenny was the second New Zealand woman graduate to train in obstetrics and gynaecology. The first was Dr Mercia Barnes.

Jenny grew up in a small rural town in the North Island, Te Kuiti and then Devonport, Auckland where she attended Takapuna Grammar School. Her mother, Mabel, was a graduate from the University of New Zealand (Auckland) and a schoolteacher with a double MA in Art and History. Her father, Norman, had served in WW1 and was awarded the Military Cross. Jennifer was the last of three daughters.

By the time Jenny started medical school, her older sister, Meredith, had already graduated in medicine. Jenny was one of only 10 women in her class at University of Otago and was top of her class at graduation in 1956. Jenny started work as a house officer at Auckland Hospital and later at National Women's Hospital. She passed the Diploma of O&G in 1959 and in 1960 Jenny was the first woman to receive the Doris Gordon obstetrics and gynaecology travelling scholarship and travelled to the UK with her husband, Trevor, who was training to be a surgeon.

In the UK, she initially had difficulty getting suitable registrar posts in O&G – she considered that being a woman with one child and training outside the UK was also against her. She eventually passed her specialist exams and was admitted as a member of the Royal College of O&G in 1963. In 1969, Jenny returned to Auckland with her two small children and started as the tutor specialist at St Helen's Hospital in Mt Albert, Auckland. This was a full-time position and the first time a woman was in this post. She then started private practice and became a part-time consultant at St Helens and later, when it closed, at National Women's Hospital.

Jenny was a very successful private O&G specialist for nearly 40 years, delivering thousands of babies. She also worked for the Family Planning Association in the 1970s and 1980s and had an interest in intrauterine devices, stemming from the backlash against IUDs following the Dalkon Shield controversy. She published a long-term study of fertility in women who had had IUDs in the *American Journal of Obstetrics and Gynaecology*, which has been cited over 80 times. She was also instrumental in starting Contraceptive Choice, a group of women doctors who wanted to counteract misinformation about contraception. This group worked for 10 years producing evidenced-based information to be used by GPs and FPA. She trained mid-career in laparoscopic surgery and, after stopping obstetrics, had a busy surgical career.

Jenny was a lot of fun – she had a distinctive laugh that will be hard to forget. And she loved her work as a doctor, reluctantly retiring in her early 70s. She had many patients who were grateful for her care and who missed her after she retired.

I would like to acknowledge Jenny and other early women doctors who paved the way for today's women consultants and trainees who no longer have the battle for training and recognition in the specialty.

Jenny's first husband, Trevor, died when Jenny was only 40 and some 30 years later Jenny married her second husband, Chris North, who looked after her so well in her final years. She is survived by two daughters, Helen and Karen, and five grandchildren.

Prof Cindy Farquhar
FRANZCOG and Jenny Wilson's niece

Remembering Our Fellows

Our College acknowledges the life and career of Fellows that have passed away:

- **Dr Margot Jocelyne Barclay**, NSW, 24 January 2020
- **Dr Elinor Catherine Hamlin**, Ethiopia, 20 March 2020
- **Dr Robert Francis Ogle**, NSW, 25 April 2020