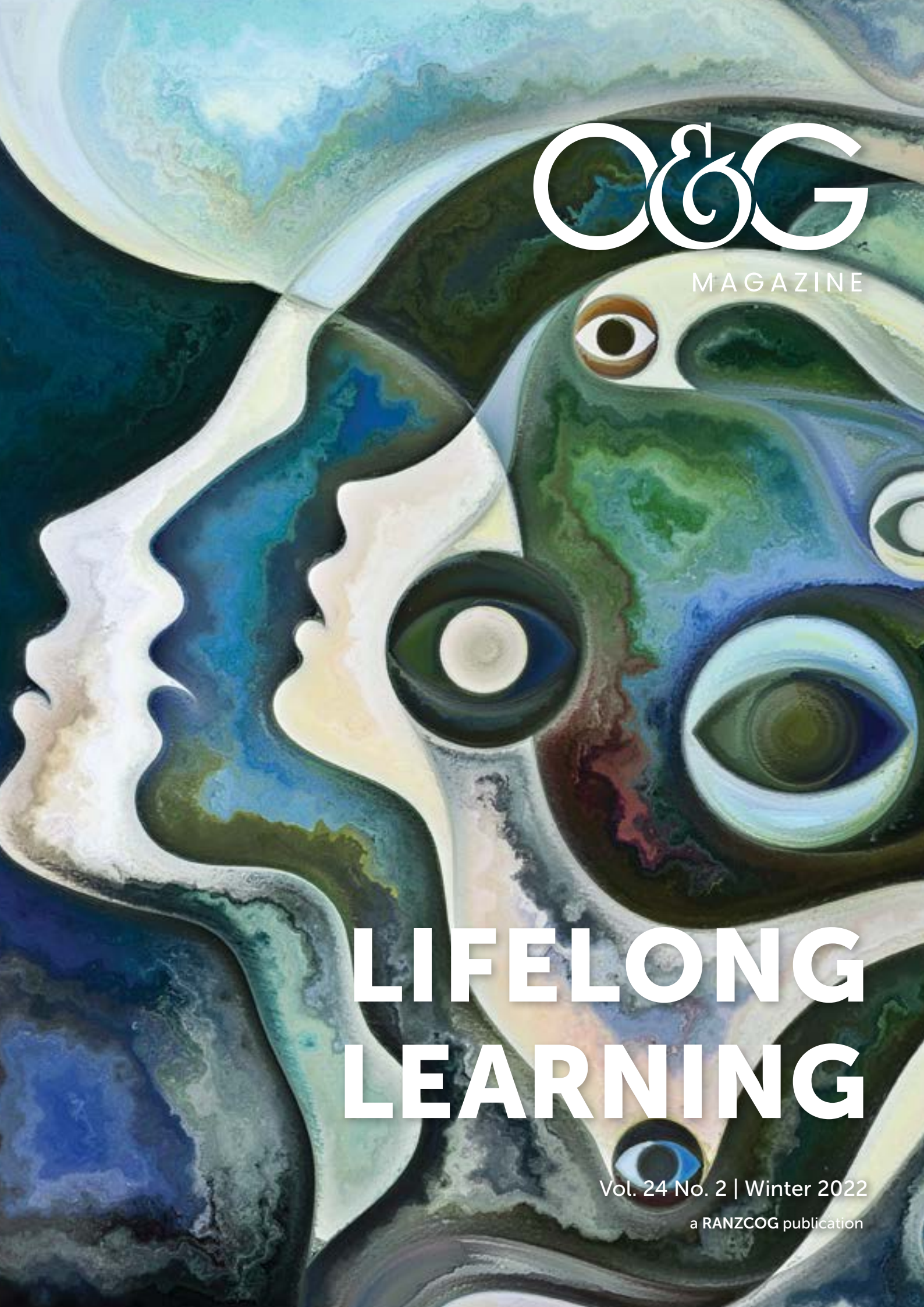


O&G

MAGAZINE

LIFELONG LEARNING

Vol. 24 No. 2 | Winter 2022

a **RANZCOG** publication

O&G MAGAZINE

Vol. 24 No. 2 Winter 2022

Editorial Communications
O&G Magazine Advisory Group
RANZCOG
Djeembana | 1 Bowen Crescent
Naarm (Melbourne), VIC 3004 Australia
(t) +61 3 9417 1699
(e) OGmag@ranzcog.edu.au

Advertising Sales
Minnis Journals
(t) +61 3 9836 2808
(e) minnis@minnisjournals.com.au

Printer
SouthernImpact
(t) +61 3 8796 7000

O&G Magazine authorised by Ms Vase Jovanoska

For further information about contributing to *O&G Magazine* visit: ogmagazine.org.au.

ISSN 1442-5319

The College

Lifelong learning

RANZCOG acknowledges and pays respect to the Traditional Custodians of the lands, waters and communities across Australia, on which our members live and work, and to their Elders, past, present and future.

Women's health

RANZCOG recognises the special status of Māori as tangata whenua in Aotearoa New Zealand and is committed to meeting its obligations as Te Tiriti o Waitangi partners.

From the President

Dr Benjamin Bopp
President

Some of us can recall when, hopefully for the final time, a pen was placed on a desktop next to a completed examination paper. That incredible feeling of relief, a weight lifted and final freedom!

As a 32 year old, I reflected on 25 years of formal education and assessment to conclude: no more ...Done.

Then along came 'lifelong learning'!

Fortunately, it became apparent that this is a formal name for what we do routinely, regularly or impulsively, to keep up to date with changes in our profession and potentially, scope of practise. Some of this learning is structured and some more random, much of it self-directed. Today lifelong learning may involve novel techniques and platforms.

Not long ago, learning required physical resources – libraries, books and journals, with other hurdles to jump over like the Dewey Decimal System, but now we all carry immediate and direct access to most world knowledge in our pocket or the palm of our hand. Unfortunately, so does everyone else. We're looking at you Dr Google!

This issue of *O&G Magazine* presents a range of titles covering how lifelong learning has evolved and the latest developments in this expanding area of professional practise. It is about educational gains, not so much what to learn but how to learn. From training apps to practise audits, patient and public health literacy, upskilling and teaching practical skills for Diplomats and Fellows, to dealing with the aforementioned evil of Dr Google, the winter issue has it covered.

In March, after a two-year absence, large RANZCOG presentation ceremonies returned with a wonderful event held in Melbourne.

This year numerous presentation ceremonies have been scheduled across Australia and New Zealand. It was a privilege to present Fellowships, certificates and College awards to worthy recipients and a happy family occasion for our new Fellows and subspecialists. These presentation ceremonies are an opportunity to congratulate and honour our colleagues and new members for their commitment, dedication and wonderful achievements – those who will continue to learn and teach.

These new specialists will now embark on the formal component of lifelong learning: continuing professional development or CPD. This issue of the magazine will also outline the latest CPD requirements as determined by the Australian Medical Council (AMC) and the Medical Council of New Zealand (MCNZ) who, as the accrediting bodies, dictate CPD and other compliance standards for the transnational specialist colleges and their members.

Please have a safe and rewarding winter and enjoy this edition of our magazine. We all look forward to the opportunity to again meet in person for our 2022 Annual Scientific Meeting, this Spring, 9–12 October on the magnificent Gold Coast!

From the CEO

Vase Jovanoska
Chief Executive Officer

Hello and welcome to this most recent issue of *O&G Magazine*, Lifelong Learning, a topic that is close to my heart. Mahatma Gandhi said, 'Learn as if you were to live forever' and I think this quote speaks to the idea that we should never stop absorbing and exploring new information and ideas. There is always something new and interesting that might enrich our view of the world.

Personally, I have learned so much in the three years that I have been at RANZCOG, both about the speciality of O&G as well as our College in general.

Our organisation is all about learning by the very essence of what we do, and we are constantly changing and evolving our standards for education and assessment as well as striving to improve and develop clinical standards for best practice.

Importantly, our College's organisational values also reflect the theme of lifelong learning. Through the provision of **Education** we embrace the opportunity to learn, share knowledge and experience through innovation, discovery, and research and are committed to **Excellence**: Performance at the highest standard, in our work, training, research and support.

During the pandemic, we learned a lot of lessons as an organisation and had to adapt quickly, as did the health services that our members and trainees work in. Ways of working that we thought were not possible in the past, we swiftly adopted, developed, and learned. Some of which are here to stay.

On the topic of learning, I am pleased to say that RANZCOG's first fully hybrid Symposium took place between 28 February and 1 March and was a great success. The event was attended by 190 online participants and 150 in person, with presentations delivered by 18 in person and 19 virtually. A highlight was the Fellowship Ceremony with 40 elevations to Fellowship and five Subspecialists.

At the Symposium, we communicated the results from the Discrimination, Bullying and Sexual Harassment (DBSH) survey that was completed by members, and published the report from the Independent Advisory Working Group. The report includes 24 recommendations, with some related to DBSH education. While there have been some improvements in this space over the last five years, there is still much more to learn and do. The action plan in response to the recommendations is currently in development and will be communicated to all members and trainees in due course.

In addition to our hybrid Symposium, March Council Week 2022 also saw some of our Board and Council return to Melbourne for face-to-face meetings and we embraced our new hybrid mode of collaboration and meetings with committees, Board, Council, the Council Forum.

At the time of writing this article, we are about to have the opportunity for meeting and connecting in Darwin for our Regional Scientific Meeting (RSM) and I am looking forward to learning about the ways in which we can better support our members who are delivering obstetrics and gynaecological services to women living in regional, rural and remote Australia.

Thanks to College President Dr Ben Bopp, the RANZCOG Board, Council, and our members, trainees and staff for your input into the development of the 2022–2024 Strategic Plan, which will guide our work over the next three years, and thank you for the work that you do for the College.

We are all in this lifelong journey of learning together.

LEADERS IN FOCUS

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

This feature sees Dr Nisha Khot in conversation with women's health leaders 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

Prof Yee Leung
MBBS, FRANZCOG, CGO

I first met Prof Leung when I started my term as councillor for Victoria and joined the Women's Health Committee (WHC). Prof Yee was the chair of WHC and to me, exemplified the ideal chairperson – inclusive yet decisive, gentle yet focused, knowledgeable yet consultative. Under his leadership, the shape of WHC changed significantly to become the modern committee it currently is. Prof Yee was also a Board member at the time and inspired first-timers like me to step outside of our comfort zone to participate in the functioning of RANZCOG confidently.

The theme for this issue is Lifelong Learning, so it seemed entirely appropriate to interview Yee, given his role as former chair of WHC as well as his ongoing interest in teaching via the Anatomy of Complications course.

Many readers will be familiar with him but for those who are not, Prof Leung is a gynaecologic oncologist based in Western Australia (WA). He was the inaugural UWA Professor in Gynaecologic Oncology in 2011. He is the Head of Department at the WA Gynaecologic Cancer Service and the Head of UWA Division of Obstetrics and Gynaecology. He served as RANZCOG Councillor as well as the Chair of the Gynaecologic Oncology subspecialty committee in addition to his roles on various College committees.

His research interests include gynaecologic oncology clinical trials, basic and epidemiological research and he helped establish a gynaecologic cancer bio specimen bank for WA. He was an associate editor of the *Journal of Obstetrics and Gynaecology* from 2014 to 2017.

Prof Yee is well known for his sartorial excellence and anyone who has known him will attest to his unique and outstanding collection of shirts.

The last two years have been difficult for all of us but particularly so for WA with strict travel restrictions. How have you been affected?

The pandemic has been a mixed blessing for me. Travel from Perth to Melbourne six times a year for Board-related activities was challenging and took me away from home and work for a week at a time. Virtual meetings caused less disruption to my working week and zero travel.

The downside is not being able to visit our son and daughter who live and work in New York City. Many of you have similar separation from family members.

What made you choose a career in O&G and the subspeciality of gynaecological oncology?

As a medical student (University of WA) and an intern (Sir Charles Gairdner Hospital), O&G was not on my aspiration list. I enjoyed psychiatry, thought surgery was interesting, and seriously considered emergency medicine as that was the new specialty in the early 1980s. After I finished my internship, we moved to Mildura since I felt that country general practice as a procedural GP would be the best fit for me.

This changed following a six-month O&G rotation with Drs Neil Fleming and John Bowditch. I learnt the importance of belonging to a 'tribe'. Neil and John, GPOs, midwives and anaesthetists were exemplary in working as a team, and I wanted to be a part of a team like this. The following year I returned to WA and was accepted into the RACOG training program.

My first term as a trainee was in gynaecologic oncology. On my first day my wife was in labour with our first child! I remember how confusing that term was, learning new terminology and concepts in oncology. The days were long. I had not considered a career as a Gynaecologic Oncologist. Midway through my training, Prof Tony McCartney and Prof Ian Hammond asked if I was interested in training to be a Gynaecologic Oncologist. My subspecialty training took me to Toronto for two years following which I completed the final year in Perth. The rest, as they say, is history.

Please tell our readers about your journey to the RANZCOG Board. What prompted you to take on leadership roles within RANZCOG?

After returning from Toronto in 1995, I became involved with RANZCOG in the WA State Committee and as a Training Supervisor. This led to involvement in the Gynaecologic Oncology Subspecialty Committee and subsequently chairing this committee. I still keep in contact with some of the College staff from those days because I was so impressed with their dedication and commitment to the process of ensuring quality training and assessment of trainees.

I am committed to contributing to the College work in ensuring women and their families have access to well-trained Fellows. The natural progression was to become involved at College Council, and then applying to be a Board Director.

I would encourage every member to consider how they can become active in College life by contributing at local, state and national levels. By doing so, your contribution will lead to the positive changes that you want to see in our specialty.

What do you see as the challenges in the future for gynaecologic oncology care?

In oncology, it is vital to work in a multidisciplinary team to ensure every patient has access to all care options. I believe the greatest challenges in the future will come from external factors related to constraints in physical spaces (access to wards, theatre, diagnostic and therapeutic services) as well as financial and human resources issues (fiscal responsibility, pandemic response). The needs of the individual will always need to be balanced by the capacity of the society to meet those needs.

The pandemic has had a dramatic effect on waiting lists and this could, in turn, have a deleterious effect on cancer care and timely access to surgery. We will have to do our utmost to ensure that we meet future demands.

What advice would you give to O&G trainees who may be considering subspecialty training in gynaecologic oncology?

Many trainees are attracted to gynaecologic oncology because of the technical expertise required in surgery. My advice is to appreciate that gynaecologic oncology is not just about surgical technical skills. It is about comprehensive patient-focused care and being meticulous about assessment and management of the patient. Be prepared for the long hours, the importance of training outside your state, the challenges of managing a team, and most of all, exercise humility at all times. This is a very rewarding subspeciality if approached with commitment and a willingness to be a lifelong learner.

There is no denying that gynaecologic oncology is a challenging subspecialty with high rates of burnout. How do you protect yourself from burnout and what advice do you have for others?

Self care is about knowing what replenishes you as well as what depletes you. For me, I take time to play tennis and to walk because I am an active person.

Prof Yee Leung.

My advice to colleagues and trainees is to partake in activities where you see people smile, like walking and skiing, and avoid activities where you see people grimacing, like swimming and long distance running! I would avoid synchronised swimming though as they are just fake smiles.

On a serious note, surround yourself with a functional team. I enjoy the company of encouragers and am frustrated by discouragers or by unnecessary systemic barriers.

In sustaining oneself, I believe it is important to recognise what your trigger points are and develop strategies to deal with these trigger points. These strategies may include putting that email aside for 24 hours, consciously leaving work behind when you drive past a particular tree on your way home or knowing when to say 'no' so you have personal time. Always keep the big picture and know what you can and cannot do.

Burnout is very real. The first step is recognising and acknowledging this. Once past this crucial step, help is available. Get help. Don't fight it all by yourself. There's nothing more lonely than trying to overcome burnout without any help.

You have been part of the team that runs the Anatomy of Complications Workshop (ACW). Could you please tell us about the workshop and what it aims to achieve?

The ACW started with Prof Ian Hammond (gyn oncologist), Mr John Taylor (urological surgeon and urogynaecologist) and Prof Paul McMenamin (professor of anatomy) designing a practical workshop to help attendees gain confidence and competence in recognising, managing, and hopefully avoiding, complications in surgery. They recognised that O&G specialists were not always confident with dealing with inadvertent

injuries to urological, gastrointestinal and major vascular structures. They believed that a thorough understanding of surgical anatomy of the pelvis underpins successful and safe surgery. This theme is fostered throughout the workshops. There are two types of two-day programs: open (standard) and laparoscopic. Medical students are able to register to observe and assist as scrub person. This provides a great experience for students who may be interested in pursuing surgery/O&G as a specialty. Both courses provide intensive, hands-on learning for specialist O&Gs at any stage of their career. The ACW is 21 years old and has held workshops in New Zealand, Hong Kong, Singapore and Ireland.

The Executive is currently led by Dr Robyn Leake, assisted by Clin A/Prof Krish Karthigasu and myself as the executive team and with administrative support from Laura Radovan. There are a number of surgical colleagues from various specialities on the advisory faculty who are also interested in high-level performance, and the ACW vision is to provide the participants with the knowledge and skills to aspire to mastery.

The format has also been updated, recognising surgery is not just a technical skill, but communication and teamwork are critical in creating the optimal environment for high performance in surgery. Dr Joseph Carpini (organisational psychologist) is also an important member of our team.

What are your future plans/projects?

My current priority is to ensure women in WA have access to evidence-based, excellent gynaecologic oncology services through the Western Australian Gynaecologic Cancer Service (WAGCS). My colleagues are Drs Raj Mohan, Chloe Ayres, Dr Emma Allanson and A/Prof Paul Cohen and we work well together in an interdisciplinary team of oncologists, palliative care physicians, gynae pathologists, radiologists, nurses, allied health and clerical staff. Health services around Australia are facing many crises, and what better time to take steps towards positive changes than during a crisis!

The Medical School is also facing challenges and the Division Heads are committed to addressing these challenges and identifying the opportunities arising from these challenges.

Finally, I need to be more disciplined in setting aside time for research projects. I am hoping that I will be able to pursue my research interests more vigorously in the coming years.

If you had to start all over again, what would you do differently and why?

I am fortunate that I look forward to going to work each day. I am still excited about the variety of clinical and surgical work, teaching and training of the next generation of doctors, research to improve outcomes for women and the opportunity to shape the future of women's cancer services in WA.

The only note I would leave my younger self is to be patient. Systemic barriers cannot be fixed overnight. The secret is to identify those who are in the best position to help affect change and developing a team approach to change management. Once you have a motivated team with you, given time and persistence, change will happen.

I hope you have enjoyed reading this interview with Professor Leung. My aim with this column is to feature women's healthcare professionals who can inspire readers, especially the next generation of O&Gs. Your feedback and suggestions are very welcome. If you have any recommendations for colleagues or mentors you would like to see featured, please get in touch. I look forward to hearing your thoughts on the current format of this feature and any ideas for improvement.

Get to know College staff: Executive Leadership Team

With so many people working behind the scenes with a shared passion for excellence and equity in women's health, here's a chance to get to know College staff and the diversity of skills and experience they bring to our vision and mission.

This issue, we focus on the Executive Leadership Team (ELT), which is the primary executive leadership body at RANZCOG.

The members of the ELT, individually and collectively, support the CEO to lead, direct, coordinate and control the operations and performance of RANZCOG, in accordance with the policies, strategy and plans approved by the Board.

Vase Jovanoska

Chief Executive Officer

Vase is responsible for leading the execution of the College Strategy as determined by the Board. Ensuring a highly effective delivery of the College's activities and programs supported by sound governance and sustainable financial operations, as well as fostering a culture of mutual respect, inclusivity, and accountability with members, trainees, staff, and external stakeholders.

Vase's corporate experience extends more than 22 years across the corporate and not-for-profit sectors, and includes strategy development and implementation, fiscal management, governance, continuous improvement, change and risk management and health policy.

Vase holds a Master of Business Administration, Master of Health and Human Services Management, and BA (Accounting). She is also a graduate member of the Australian Institute of Company Directors, a qualified CPA, and a Fellow of the Institute of Managers and Leaders, Australia, and New Zealand. Vase has also completed the Executive Program in Leading for Strategic Change with Melbourne Business School, the Women's Executive Leadership Program and Negotiations Strategies Program with Yale University.

Catherine Cooper

Head of Aotearoa New Zealand and Global Health | Kaiwhakahaere Tari Aotearoa

Catherine leads the Aotearoa New Zealand Office and the Global Health Unit. In her nearly three years at RANZCOG, Catherine has worked closely with Te Kāhui Oranga ō Nuku, He Hono Wāhine and the staff team, focusing on New Zealand advocacy activities, RANZCOG's commitment to te Tiriti o Waitangi, the development of Te Rautaki Māori me Te Ara Whakamua (RANZCOG's Māori strategy) and liaising with other organisations like the Ministry of Health, the New Zealand College of Midwives and other medical colleges.

Catherine started off in the public service, but since having children has worked in not-for-profit (for purpose) management. Her most recent role was as General Manager New Zealand of Resolution Institute, a trans-Tasman membership organisation of mediators, restorative justice facilitators and other dispute resolvers, providing training, accreditation, professional development and advocacy for members. Catherine also has governance experience, chairing two school Boards. Catherine has a Masters in Management and a BA in Psychology and Education.

Michelle Zhang

Head of STP, Finance and Risk

Michelle manages collegewide financials and oversees the government-funded Specialist Training Program, working collaboratively and effectively with internal and external stakeholders through comprehensive understanding of College initiatives and activities in preparing budgets and reports, as well as directing grant administration in program delivery.

Michelle is a certified practising accountant (CPA) and holds a Master of Professional Accounting (MPA) with more than 15 years of experience in financial and management accounting, project management and data analysis, across public and not-for-profit sectors.

Sudi Sekhar

Executive Director, Innovation, Learning and Quality Assurance

Sudi is responsible for the provision of executive leadership as part of the College's Executive Leadership team, and is the Executive Director for the Innovation, Learning and Quality Assurance directorate. The directorate provides several member-facing services including membership support, continuous professional development, research and policy, publications and media, eLearning and quality assurance programs.

Sudi's experience extends over 14 years across tertiary, not-for-profit and health sectors, and includes strategy development and implementation, project management, strategic partnerships, business development, change management and client services.

Sudi holds a Master of Business Administration, Master of International Business, and a Bachelor of Chemical Engineering. He is a member of the Australian Institute of Company Directors as well as the Fundraising Institute of Australia. Sudi also holds an Agile Practitioner (AgilePM) qualification.

Mel Pietsch

Head of Engagement and Rural Health

Mel is responsible for overseeing the State and Territory Offices, college Events Team, Commonwealth-funded Rural Health initiatives and is involved in the College government relations activities. In her nearly two and a half years at RANZCOG, Mel has worked with the State and Territory Committees and State and Territory Training and Accreditation Committees and various other working groups along with her team, focusing on engagement, advocacy and continued service delivery and support during the evolving pandemic.

Mel previously worked for the Commonwealth Department of Health, where over her 15-year career she progressed through various roles and units where she developed a strong understanding of the medical training system and relationships with universities, specialist medical colleges and state and territory health departments. In her most recent role as Assistant Director, she was responsible for the policy and program management for the National Specialist Training Program. Mel has a Certificate III in Financial Services, Diploma in Specialist Makeup Services and is currently undertaking a Certificate in Effective Business Management.

Daniel Petkovski

Head of People, Wellbeing and Facilities

Daniel is responsible for leading the People, Wellbeing and Facilities team. During his four years at RANZCOG, Daniel has overseen the Human Resources function and the implementation of several wellbeing, diversity, and inclusion initiatives for RANZCOG members, trainees, and College staff. His team is responsible for delivering the Fostering Respect Action plan, providing confidential and impartial support for trainees, the Reconciliation Action Plan and projects that support First Nations people.

Daniel is also responsible for commercial leasing, building and facilities management and oversaw the College's relocation to Djeembana (College Place).

His career encompasses experience within community health and the not-for-profit and commercial sector. He is passionate about organisational development, wellbeing, advocating for staff and fostering positive workplace culture. Daniel is a member of the Australian HR Institute (AHRI) and holds a Bachelor of Business (Human Resource Management).

Dr Bill Warren

Executive Director, Education

Bill is responsible for leading the Education directorate, overseeing teams that deliver a broad range of College educational activities, including examinations, curriculum development, accreditation, program evaluation, SIMG assessments as well as Subspeciality and FRANZCOG, DRANZCOG and CWH programs support and performance monitoring.

Bill joined RANZCOG in October 2021 after more than 25 years of medical and tertiary education expertise gained in Australia and overseas. He has extensive university teaching and biomedical research experience as well as four years of hospital-based medical officer education and performance monitoring across Queensland and the Northern Territory.

Bill received a PhD in Molecular Sciences from the Australian National University in 1991 then gained further specialist knowledge of genetic health and medical research as a laboratory-based research scientist specialising in cancer genetics. He then went on to undertake a Masters Degree in Education Management at the University of Melbourne and an academic career developing innovative undergraduate medical education curricula in the areas of cell biology, genetics, pathophysiology and cancer pathobiology.

Editorial

Dr Jenny Dowd
B Med Sci, MD, FRANZCOG

Lifelong learning is the ongoing, voluntary and self-directed pursuit of knowledge for either personal or professional reasons. In this issue of *O&G Magazine*, we concentrate on the professional side, while acknowledging the importance of learning in fields outside this realm. How many of us found new skills or interests during the recent pandemic lockdowns in order to maintain our physical, mental and social wellbeing? Sourdough anyone? Tik Tok dancing?

The principles of acquiring new skills or reinforcing those we already have crossover between the personal and professional. We can not only learn in a formal didactic way but by doing, teaching, reviewing and reflecting, listening to others and giving and receiving feedback. We learn from written, visual and auditory sources, and also from interacting with colleagues, patients and incorporating our own life experiences.

As professionals we are seen as a disciplined group of individuals who 'adhere to ethical standards and who are accepted by the public as possessing special knowledge and skills in a widely recognised body of learning derived from research, education and training at a high level, and who are prepared to apply this knowledge and exercise these skills in the interest of others.' (Australian Council of Professions, 2003)

Part of living up to these standards is not only to maintain our skills and knowledge, but to be seen to be doing so. Hence what some may see as the imposed regulation and documentation of CME or CPD. As explained in the article on CPD, The Medical Board of Australia and the Medical Council of New Zealand, Te Kaunihera Rata Aotearoa, will soon dictate how CPD will be structured into the future. The new format and resources developed by RANZCOG have been designed to make the process easier for Fellows and members to comply, and so make it as streamlined as possible to make our College your CPD home.

While we all accept that keeping up to date is imperative, it may be time to look more laterally at how and why we learn. In this issue we discuss some of these theories and hope to inspire you to perhaps branch out and try new approaches. What type of learner are you? What is the importance of psychological safety when giving feedback and interacting in teams?

How can we learn to provide information in a way that best suits our patients? We have two articles from our Consumer Network as part of their ongoing contribution. We should acknowledge the importance of learning from the lived experience of our patients and remember the social determinants of health. We need to understand levels of health literacy and how people use the Internet to explore symptoms and diagnoses.

Learning needs change throughout a career. From the obvious basic clinical skills acquired when entering a training program, to the structured gaining of responsibilities, the subtleties of dealing with complex emotions, the choice of specialised fields or areas of interest and settling into formal ongoing CPD throughout a career.

In mid-career we are often at the peak of our performance but also the most busy, and may not take time to reflect, and as we age we may find it difficult to adapt to new technologies such as paperless hospital record systems. Finally, we need to learn when and how to slow down, accept the limitations of advancing years on our senses and reaction times and perhaps change career direction before eventually retiring.

In a surgical speciality it is obviously important to keep up to date with new practical skills and equipment. New minimally invasive surgical techniques such as robotic surgery are not for everyone, but even in obstetrics new diagnostic and therapeutic procedures appear. We should now be offering patients (hopefully pre-pregnancy) the option of various genetic screening tests, and be familiar with procedures such as B-Lynch sutures, Bakri balloons, fetal pillows for the generalist and intrauterine surgery for the dedicated few subspecialists.

What can be more challenging is keeping up to date with social changes. Understanding cultural sensitivity may mean accepting our own privilege and facing our ethnocentricity. We may need to face our own, perhaps unrecognised, prejudices when caring for people who identify as trans or nonbinary. Lifelong learning involves self reflection and possible training in areas such as team building, managing bullying accusations or becoming a peer messenger as part of patient safety campaigns.

RANZCOG understands the difficulties of collecting CPD points for Fellows who are semi-retired or not associated with a teaching hospital and are looking for ways to offer more options in the CPD Resource Guide. Several of our articles outline College activities with respect to the various curricula, the role of hospital accreditation visits and programs to upskill those in more remote locations. There are good suggestions from those in the field about digital platforms and electronic means of interacting with colleagues to undertake morbidity and mortality audits and case reviews.

We all need to keep up to date with basic emergency drills, but should we also question how we perform routine procedures once competent? Operate with a colleague or undertake surgical coaching? Perhaps have a practice visit to get an external perspective on how your business functions. Conduct audits of various kinds (clinical, patient satisfaction), which if well planned and reviewed can lead to meaningful changes, and good CPD points!

We all engage in ongoing learning in many areas of our lives whether formally recognised or not. We are, however, required to participate in a professional capacity and document what we do, so hopefully the articles presented here inspire you to think more laterally and find new ways to enhance your skills.

Now, who has done today's Wordle?

What kind of learner are you?

Dr Sam Holford
MBChB, BSc(Hons), PGDipOMG
FRANZCOG Trainee
Counties Manukau Health, Auckland

Are you a visual learner? Or do you learn best by doing, or by reading a textbook? Does a podcast or audiobook work best for you?

The concept of learning styles states that people can be classified according to a content delivery method, or style, that differs between individuals: we learn best when our suited learning style is used.

Many models of learning styles have been described, but by far the most common is New Zealander Neil Flaming's VARK model.[1]

In the VARK model, there are four sensory modalities:

- Visual learners: pictures or demonstrations
- Auditory learners: listening to an explanation
- Reading/writing learners: text
- Kinaesthetic learners: physically interacting with the world (doing)

Development of the VARK model was based on the observation that some excellent teachers did not reach all students effectively, while some bad teachers manage to teach a subset of students well.

This led to the idea that if learners could be classified by their innate learning style, then they could be taught more effectively using their individually suited modality.

In practice, a VARK questionnaire can be used to divide a class of students into visual, auditory, reading/writing, and kinaesthetic learners. The same curriculum can then be delivered in these different formats. According to the learning styles hypothesis, these students will learn better, and therefore have higher performance in an assessment, than if they were all taught together with the same method.

This is just common sense though right? As someone who has spent their entire life learning, you probably have a preferred learning style, or at least a style you dislike. Perhaps you would prefer to do all of your learning through a book, or via a podcast as you commute to work.

Learning styles are a myth

Sorry to bury the lead, but in fact, disability aside, that we each have individual learning styles is a myth. We may have a preference of how we like to learn, but there is a large body of evidence refuting that we learn better by using a preferred learning style.

This may at first be hard to accept. Afterall, belief in the utility of learning styles is more common than not, even amongst educators and scientists.[2] On a more personal level, the corollary that we all learn in the same way conflicts with our desire to be unique, as well as our past experiences.

You might consider yourself a visual learner, and recall diagrams from medical school or a textbook that you can still picture today. But what about the auditory learning experience of being grilled by your consultant that you'll never forget? Or the kinaesthetic sensation of a Veress needle traversing the layers of the abdominal wall. Would you have learned these better with a diagram?

You may also be, or know, a musician who can hear and understand pitches and tones more effectively than others. But although that person is better suited to learning music, a map will still be best for learning geography.

Evidence

There are two facts at the core of the myth:

1. Many people have a preference for how they receive information.
2. Evidence suggests that teachers achieve the best educational outcomes when they present information in multiple sensory modes.[3]

A landmark article evaluating learning style literature published in an Association for Psychological Science journal in 2009 found a lack of evidence to support the use of learning styles.[2] It concluded that, at present, there is no adequate evidence base to justify incorporating learning style assessments into educational practice.

Evidence to support use of learning styles should come from randomised controlled trials (Figure 1). A group of students complete a questionnaire to determine their preferred format; for example, visual learners and reading/writing learners. They are then randomised to use either their preference, or the alternative. Only if those using their preferred learning style outperform the others, in both groups, do the results support the hypothesis.

These trials have been conducted, and a follow-up review in 2015, incorporating these high-quality studies and concluded that the evidence for

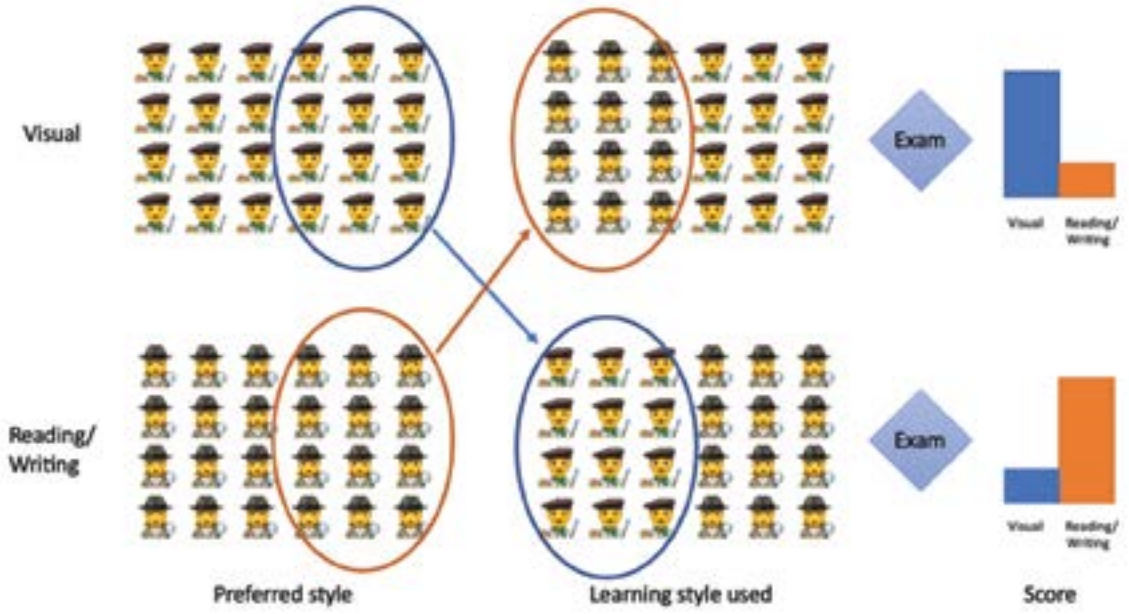


Figure 1. Randomised controlled trial design with visual and reading/writing learning style arms. Exam scores shown would support the effectiveness of using a preferred learning style, but this is not observed in trials.

learning styles was virtually non-existent, while evidence contradicting it was both more prevalent and used more sound methodology.[4]

Regarding subject-specific matter, a 2018 study of 426 university anatomy students surveyed their learning styles using an online VARK questionnaire at the beginning of the semester.[5] At the end of the semester, students reported poor correlation between their utilised study method and their preferred learning style. Those that did employ their preferred learning style performed no better than their peers. Similar studies have reported similar conclusions.[4]

Delivery of a curriculum using learning styles is resource intensive. It requires determination of each student's learning style and preparation of educational material in multiple formats. Furthermore, certain styles may be less engaging, or time inefficient, reducing their uptake by learners.

Limitations

Evidence aside, it must be stated that utilising a preferred learning style is not without merit. The studies that make up the evidence base have focused on examination performance as the primary outcome. It is not known if this translates to long-term retention of information, nor enjoyment, engagement, or satisfaction with education.

Radiology podcasts, which seem to be an oxymoron, are popular, enjoyable, and a safe way to learn radiology while driving. Learning a visual specialty through audio alone is probably suboptimal (though evidence is lacking), but is certainly competitive with a textbook or computer screen while on the motorway.

Better ways to learn

The way that we teach and learn can always be improved. There is evidence to support multimodal teaching, which can simply be thought of as combining learning styles, such as the use of words with pictures rather than a picture alone. More complex examples include cognitive training combined with non-invasive brain stimulation and physical exercise training, or active control training in adaptive visual search and change detection tasks. Multimodal methods have been shown to significantly enhance learning and promote skill learning across multiple cognitive domains.[3]

Microlearning refers to short learning activities with microcontent.[6] This is facilitated through small learning units and short-term educational activities. The most obvious examples of microlearning are abundant on TikTok, YouTube, and Instagram, but can also be found on posters and screensavers in hospitals, or delivered in the form of quick learning points at the beginning of handover. Macrolearning focuses on education at a larger scale, at the level of institutions and schools. A curriculum is delivered over a longer period of time and may incorporate a spiral or progressive approach. Macro/micro learning is a new research paradigm, and while not as well studied or described as learning styles, shows obvious promise in terms of engagement and accessibility.[7]

Inference

There are still good and bad ways to learn. They are just not dependent on the individual learner. Accept the evidence and acknowledge that bias perpetuates the myth that we each have a unique learning style. Employ the teaching modality best suited to the subject matter, and consider optimising content delivery through multimodal and macro/micro education.

If you remain unconvinced, try another learning style:

- Veritasium. The Biggest Myth in Education (YouTube).[8]
- Skeptoid Podcast. Learning Styles, Re-examined.[9]

References

1. Fleming ND. Teaching and learning styles: VARK strategies. 2001. Christchurch, New Zealand.
2. Pashler H, McDaniel M, Rohrer D, et al. Learning styles: Concepts and evidence. *Psychol Sci Public Interest.* 2009;9(3):105-19.
3. Ward N, Paul E, Watson P, et al. Enhanced learning through multimodal training: evidence from a comprehensive cognitive, physical fitness, and neuroscience intervention. *Sci Rep.* 2017;7(1):1-8.

Full Reference list available online

How has lifelong learning evolved?

Dr Danny Tucker
MBBS, MRCOG, FRANZCOG, AFRACMA

The past 100 years of medicine have seen an evolution of the practice, in both medical expertise and non-technical expectations of the doctor's role (Figure 1). Although drivers, content, and methods have changed, learning and teaching within the craft have remained a constant requirement.

The changing role of medical practice

The foundation of medical colleges in Australia between 1920–1950 led to the dominance of teaching hospitals and the rise of subspecialties by 1975.[1] Alongside these changes, senior doctors were engaged as clinical leads, medical managers and medical leaders. This terminology reflects not simply a change of title but a shift in role as the complexity of healthcare and health systems has evolved.

The preceding three centuries were dominated by a model of understanding based upon superficial, linear, hierarchical relationships. Complexity science and healthcare as a complex adaptive system inform a modern interpretation of our work, primarily driven by rapidly changing technology and information.

Where traditional systems thrived on stabilisation, control, rigidity and knowledge-as-power, complexity demands attention to connections, relationships and styles of practice and leadership outlined in Table 1. In this environment, lifelong learning has undergone a similar transformation of context, content and how we maintain skills across these broad domains of practice.[2]

Healthcare regulation as a driver for lifelong learning

With an increasing demand for accountability and transparency, there is pressure by the public on legislators to safeguard high-quality care and patient safety, and to ensure that all doctors are competent. Certification of specialists and specialty practice varies worldwide, so colleges need to assess internationally qualified specialists as suitable for unsupervised practice in Australia. Once specialist qualification is achieved, there are a range of methods for recertification. The RANZCOG Continuing Professional Development (CPD) program requires 50 hours per year across the three domains of educational activities, outcome measurement and performance review. UK recertification is carried out five-yearly and includes collation of a portfolio like RANZCOG, with additional evidence of significant clinical events and feedback and review of complaints and compliments from patients and colleagues. Recertification in the UK also requires annual appraisals by employers. There has been a call for international evidence-based consensus for CPD and lifelong learning frameworks.[5]

Lifelong learning approaches

Lifelong learning is described as 'the development of human potential through a continuously supportive process which stimulates and empowers individuals to acquire the knowledge, values and skills and understanding they will require throughout their lifetimes and apply them with confidence, creativity and enjoyment in all roles, circumstances and environments.'[3] This somewhat wordy definition emphasises the importance of metacognitive and meta-learning skills (thinking about how we think and learn) across situations in which we

Table 1. Leadership traits in different systems.[10]

Healthcare professionals in: Traditional systems	Complex adaptive systems
Are controlling, mechanistic	Are open, responsive, catalytic
Repeat the past	Offer alternatives
Are 'in charge'	Are collaborative
Are autonomous	Are connected
Are self-preserving	Are adaptable
Resist change, bury contradictions	Acknowledge paradoxes
Are disengaged, nothing changes	Are engaged, continuously emerging
Value position and structure	Value persons
Hold formal position	Are shifting as processes unfold
Set rules	Prune rules
Make decisions	Help others
Are knowers	Are listeners

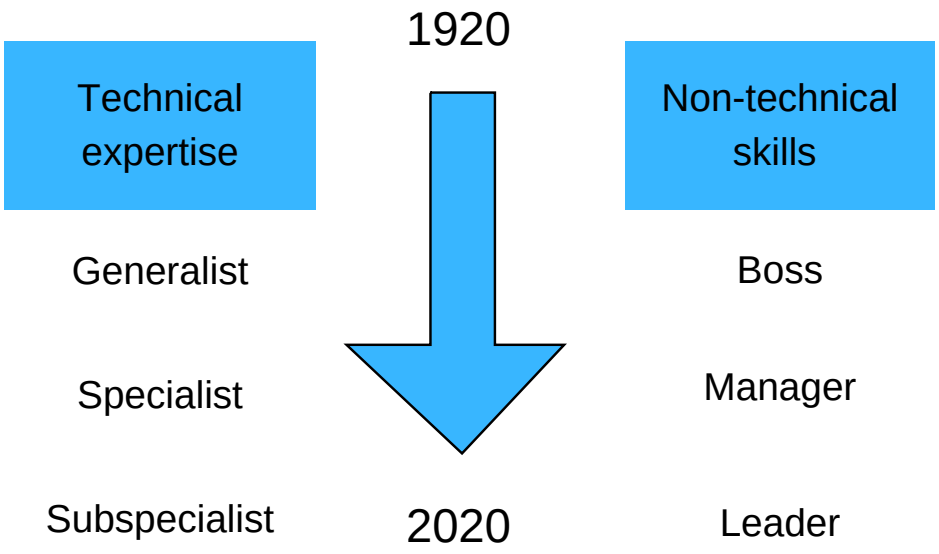


Figure 1. Evolution of the medical expert and clinical leader.

work. A fundamental aptitude is self-awareness of our limitations of thinking and the ability to adopt different mental models for a changing and unpredictable environment. Cognitive neuroscience has taught us much in recent years about learning more effectively.

Undergraduate education methods are well studied; however, little is known about active engagement in lifelong learning within contexts other than those dedicated to learning. This is important because a significant component happens within the clinical space and situations not intrinsically suited for active learning.

Self-regulated learning (SRL) describes the process of goal setting, planning, monitoring, metacognition, attention, learning strategies, persistence, time management, motivation, emotional control and effort. This often occurs as part of a structured training program in postgraduate medicine, such as one for college Fellowship. There has been a shift, and recent studies indicate that trainees engage in self-regulated learning before, during and after patient encounters, use feedback on performance for self-reflection and to guide learning.[4] This may suggest that efforts to make undergraduate medical education more active, learner-centred and self-regulated have also affected postgraduate development.

Social relationships, workplace-based learning, feedback and self-reflection on real issues encountered in a doctor's life whilst practising medicine are essential for acquiring and improving competencies.[3] Reflective practice aids professional development, reduces diagnostic errors[6] and can help process emotions, improve mood, prevent burnout and improve patient care.[7]

Incremental learning is well established and known to us: we learn facts and technical skills and align habits with established norms and expert opinions. Transformative learning is how we internalise and interpret our own experiences to date. The transformation is a more profound developmental shift, where situations and dilemmas challenge our underlying assumptions and beliefs about the world. Transformative learning changes perspectives and relationships, laying the foundation for personal growth and innovation. It requires curiosity, attention, and courage. Adult learners embrace transformation if they feel the goals are worth attaining and they have control over the learning process.[8] Table 2 outlines what to expect from transformative and incremental learning.

How can we inspire transformational learning in the workplace? Here are a few examples:

- An Indigenous patient discharges against medical advice. The supervising consultant asks their resident medical officer (RMO) to spend time with the ward social worker and Indigenous liaison officer to understand more about this patient's situation. They work with the patient to find a compromise to ensure ongoing care is provided within the individual's context of holistic health. The RMO is encouraged to discuss their learnings at handover the following day.
- A consultant has a relationship with a national patient organisation and involves their training registrar. During the year, the registrar orientates a patient advocate into a hospital working group, authors an article for patients about how to navigate the healthcare system and helps develop an online patient information resource.
- A team-building exercise is planned between midwives and obstetricians. They debate 'Caesarean section on demand should be freely available in public hospitals.' The midwives must present the affirmative argument and the obstetricians the negative.

Table 2. Incremental versus transformative learning: what to expect.[9]

	Incremental learning	Transformative learning
Personal value	Knowledge and skills	Purpose and presence
Organisational value	Alignment and preparation	Innovation and empowerment
Space for learning	Boot camp	Playground
Source of learning	Experts (models)	Experience (moments)
Work required	Deliberate practice	Reflective engagement
Marker of progress	Approaching ideals (closing the gap)	Redefining ideals (making room)
Aim of process	New action (a better way)	New meaning (a better why)
Role of supporters	Focusing practice	Inviting interpretation
Effect on power structure and culture	Affirmation	Subversion

Transformative learning more commonly comes from everyday activities, but the key is to recognise the opportunity as it presents, to slow down and make space for it.

Steps of transformative growth include four stages, described by Petriglieri.[9]

1. Note the experience. How did it make you feel? What happened when you reacted differently, or your prior beliefs were challenged?
2. Voice what happened. Discuss with others and see what their response is. What patterns do you notice? Reserve judgment and describe it, keeping your mind curious.
3. Interpret the experience. Why did it go the way it did? Avoid usual thinking, eg. 'because we've always done it that way' or traditional relationships and structures. What novel interpretations could explain it? What are the implications for future situations: both similar and dissimilar? What did you learn?
4. Own it. How does the experience fit with your prior personal beliefs? Now bring the past and the future into the conversation. What does it mean for the relationships involved and the team culture? How can you build confidence in new ways?

Online learning and social media

The role of e-learning for the lifelong learner has yet to be established, despite early adoption by the medical profession for CPD activities. Described benefits include the flexibility of self-paced learning, including case studies, 'just-in-time' knowledge and a systematic and logical approach from simple to complex information delivery. Challenges include self-discipline requirements from learners and an abundance of poor evidence-based education and training. E-learning is a time-, cost- and labour-intensive approach;[11] however, the physical restrictions of the coronavirus pandemic have made it more common – if not more popular – than face-to-face conference events for CPD.

Doctors' use of social media to supplement previously described learning approaches is well described, especially Twitter as a resource for dissemination, disruptive peer review and FOAMed – free open access medical education.[12] The Society of American Gastrointestinal Endoscopic Surgeons reports using a Master's Program closed Facebook group dedicated to sharing surgical video clips for peer review and feedback.[13] The evidence for its use remains descriptive in nature.

Conclusion

There is no doubt that as the context of medical practice evolves further, our approaches to lifelong learning will adapt. Currently, expectations of the breadth of skills required for medical practice have outpaced evidence to inform the best resources and methods for lifelong learning. A priority for trainees and lifelong specialist practice is to continue to develop non-technical skills, including a deeper understanding of complexity science, metacognition, meta-learning and the importance of mental flexibility for personal and professional growth.

References

1. Story ES. A brief history of the specialties from Federation to the present. *Med J Aust.* 2014;201(1): S26-S28
2. Launer J. Complexity made simple. *Postgrad Med J.* 2018;94:611-2.
3. Berkhout J, Helmich E, Teunissen P, et al. Context matters when striving to promote active and lifelong learning in medical education. *Med Ed.* 2018;52:34-4.
4. Sagasser M, Kramer AWM, Fluit C, et al. Adv *Health Sci Educ Theory Pract*. 2017;2(4):931-49.
5. Aboulsoud S, Filipe HP. CPD and lifelong learning: a call for an evidence-based discussion. *MedEdPublish*. January 2019. Available from: doi.org/10.15694/mep.2019.000001.1
6. Gostelow N, Gishen F. Enabling honest reflection: a review. *Clini Teach.* 2017;14(6):390-6.
7. Veno M, Silk H, Savageau JA, et al. Evaluating one strategy for including reflection in medical education and practice. *Fam Med*. 2016;48(4):300-4.
8. Rashid P. Surgical education and adult learning: Integrating theory into practice. F1000Res. 2017;6:143. doi:10.12688/f1000research.10870.1
9. Petriglieri G. Learning for a living. MIT Sloan Management Review. 2019. Available from: sloanreview.mit.edu/article/learning-for-a-living.
10. Haupt J. Applying complexity science to health and healthcare. Plexus Institute. 2003. Available from: amee.org/getattachment/AMEE-Initiatives/ESME-Courses/AMEE-ESME-Online-Courses/Leadership-Online/ESME-LME-Resources/Applying-Complexity-Science-to-Health-and-Healthcare.pdf
11. Regmi K, Jones L. A systematic review of the factors – enablers and barriers – affecting e-learning in health sciences education. *BMC Medical Education*. 2020;20:91. https://doi.org/10.1186/s12909-020-02007-6
12. Mandrola J, Futyma P. The role of social media in cardiology. *Trends in Cardiovascular Medicine*. 2020;30:32-5.
13. Jones D, Stefanidis D, Korndorffer JR, et al. SAGES University MASTERS Program: a structured curriculum for deliberate, lifelong learning. *Surg Endosc.* 2017;31:3061-71.

The RANZCOG CPD Program

A/Prof Boon H Lim
Chair, CPD Committee

Jacky Heath
Head of Learning and CPD
Innovation, Learning and Quality Assurance

Continuing Professional Development (CPD) promotes a reflective approach to learning, which means we are all responsible for identifying our learning needs that are relevant to our scope of practice. Whilst CPD is often interpreted as mandatory training, it is important to recognise its value in assisting clinicians to continually upskill and identify any knowledge gaps. This leads to increased overall competency to provide the highest quality of care to our patients.

Participation in CPD activities has always been a requirement from the regulatory bodies for renewal of registration. Following a period of consultation, both the Medical Board of Australia (MBA) and Medical Council of New Zealand (MCNZ) announced changes to the CPD requirements for doctors, with new domains and the minimum hours required. The CPD Department and Committee have developed the CPD Framework, which is a comprehensive list of activities to help you plan your professional development across the three domains of **Educational Activities, Outcomes Measurement** and **Performance Review.** This Framework is an evolving document that will be updated to include guidance for those Fellows that are practicing part-time, semi-retired, in private practice and/or in rural areas.

If you are involved in any College-related activities, RANZCOG staff will liaise with the CPD team to update these hours into the CPD platform on your behalf.

It is important to note that the minimum CPD requirements are stipulated by both regulatory bodies and the College's role is to facilitate and support Fellows with the implementation of the CPD requirements.

Impact of COVID-19 on CPD participation

It is recognised that all Fellows and members have had their CPD impacted by the effects of the pandemic over the last two years. In response to the announcements by the MCNZ on 25 March 2020 and the MBA on 30 March 2020, the RANZCOG Board granted Fellows and members an exemption from participation in the 2019–2022 RANZCOG CPD program effective 25 March 2020 until 28 February 2021. Updates from both the MBA and MCNZ have since confirmed that any exemption period will not be extended and therefore Fellows and members of the College are required to meet their CPD requirements from 1 March 2021. Please note your CPD portal has been updated accordingly to reflect the required number of CPD hours for the remainder of this triennium. Further information is available from the COVID-19 CPD FAQs web page (ranzcog.edu.au/statements-guidelines/covid-19-statement/covid-19-cpd-faqs).

New changes to the RANZCOG CPD program from 1 July 2022

The RANZCOG CPD program will change from the current triennium to an annual cycle, effective from 1 July 2022, to align with updated MBA CPD Registration Standards and MCNZ Recertification Requirements. As the new MBA and MCNZ CPD cycles are to commence from 1 January of each year, the Board has approved a transitional change allowing the new CPD cycle to run for 18 months from 1 July 2022 to bring the CPD program into a calendar year cycle as required by the MBA. Some requirements have already been implemented to the current CPD program. Once the transition is completed, the annual CPD cycle will begin from 1 January every year from 2024.

Current triennium (2019–2022) requirements

RANZCOG is now in its final year of the CPD triennium (2019–2022) where Fellows and members must meet their CPD requirements before 30 June 2022. CPD updates have already been communicated via email along with several CPD information webinars. Further webinars are scheduled for 2022 and dates can be located on the CPD update web page (ranzcog.edu.au/members/cpd/fellows/cpd-program-from-1-july-2022).

Please refer to Figures 1 and 2 for further information.

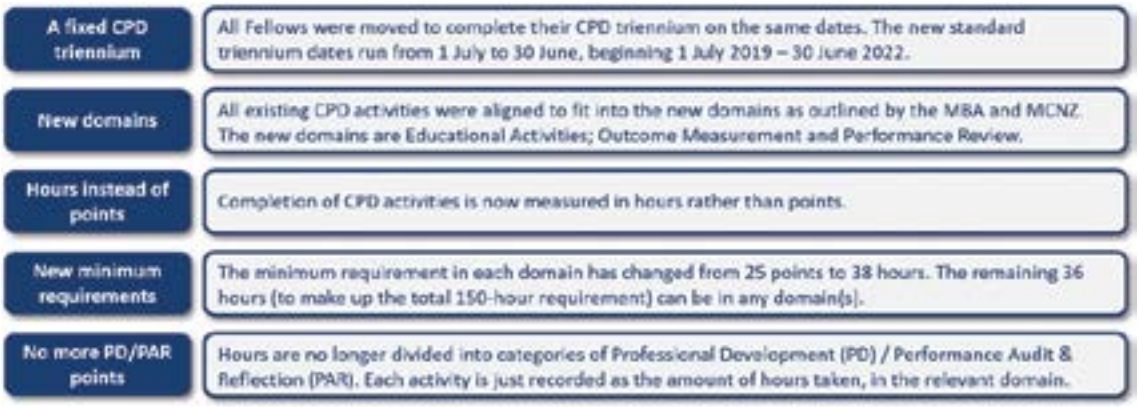


Figure 1. As a reminder, the above changes were applied in 2019 for the current triennium (2019–2022).

CPD verification and overdue Fellows

In May 2022, 7% of Fellows will be randomly selected for a verification check of the CPD they have claimed during their 3-year CPD period. Selected Fellows are required to provide verification documentation as evidence of their participation in their logged activities.

Fellows who:

- have previously been selected are not exempt from verification checks in future CPD periods.
- are one week (or more) overdue submitting their CPD requirements will be automatically selected for a verification check.
- fail to provide verification of their CPD activities within five weeks will be referred to the Fellowship Review Committee (FRC).

Further information is available on the CPD web page (ranzcog.edu.au/members/cpd/fellows/verification-checks)

Overseas Fellows

If you are practicing overseas, you must continue to meet your CPD requirements either with the RANZCOG CPD program or with a recognised international CPD program. You may be eligible for a reduction in your RANZCOG subscription fee.
If you are participating in a CPD program that is not currently recognised by RANZCOG, you may make an application to the RANZCOG CPD Committee for recognition of the program you are participating in. Further information is available on the CPD web page.

Move to annual CPD program

To align with changes in the MBA CPD Registration Standards and MCNZ Recertification Requirements, the RANZCOG CPD program will transition to an annual CPD program effective 1 July 2022.

The new cycle, commencing 1 July 2022, will be extended to 18 months and conclude on 31 December 2023. This cycle will be considered 'transitional' to enable Fellows and members to understand the new requirements and bring the CPD program into a calendar-year cycle that is now required by the MBA.

For the annual CPD cycle, Fellows and members will be required to record a minimum of 50 CPD hours each year, across the three domains, as outlined in Table 1.

Revised annual CPD requirements for subspecialists

- To align to an annual CPD cycle, 35 of the 50 hours must be specific to the subspecialists' scope of practice.
- Subspecialty checklists for CREI and CU will be removed, and criteria incorporated into the Professional Development Plan (PDP).
- CGO subspecialists will be required to undertake a minimum 20 hours of multidisciplinary team meetings (MDT) each year.

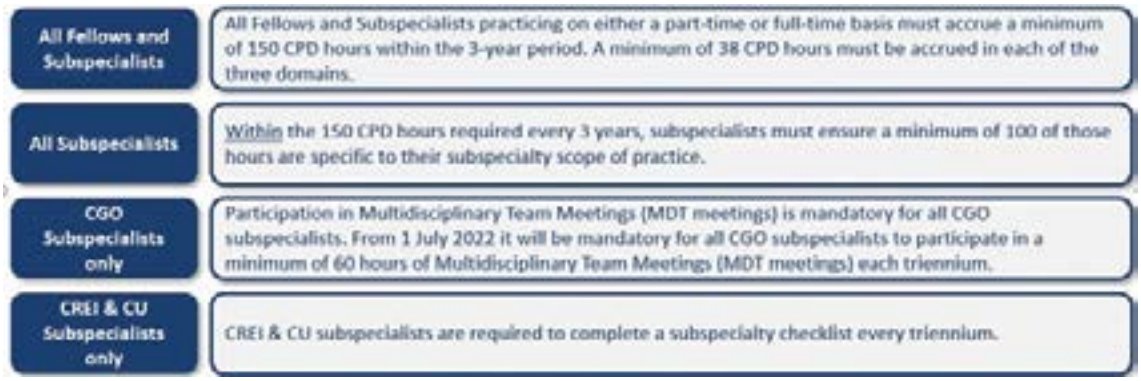


Figure 2. Existing requirements for Fellows and Subspecialists

Table 1. Revised allocation of hours for Outcome Measurement (OM) and Performance Review (PR)

Total (hours)	Educational Activities (EA)	Outcome Measurement (OM)*	Performance Review (PR)*	Remaining OM/PR	Remaining Hours
50	13	5	5	16	11

* A revised allocation of hours for OM and PR that will require a minimum of 50% (25 hours) **across both** domains with a **minimum** of five hours within each.

- Please note the number of hours will **not** be increased during the 'transitional' 18-month period and will remain as a minimum 50 hours.

* These revised minimum hour requirements under OM and PR have also been applied for the remainder of the current triennium (2019–2022) to help Fellows, particularly part-time, semi-retired and rural Fellows. Updates have been reflected in My.RANZCOG.

Professional Development Plan

The PDP is a planning tool to guide Fellows and members future CPD throughout their career and can be used to identify development needs, both personally and professionally, and help guide changes for improving their own health and wellbeing. Completion of the PDP will be a mandatory annual requirement from 1 July 2022 under the Performance Review domain where a RANZCOG PDP template will be available. It is recognised that Fellows and members may already have their own professional development plan, and this can also be uploaded. Further information will be made available from the CPD webpage.

Annual conversation

From 1 July 2022, New Zealand Fellows will be required to undertake a structured conversation, at least annually, with a peer, colleague, or employer about their clinical practice. The intent of this activity is to provide time for the Fellow/member to reflect on their development needs, their goals for learning and professional activities and their intentions for the next year (PDP). It provides an opportunity to receive constructive feedback and share best practice. Further guidance to undertake the Annual Conversation will be made available from the CPD webpage.

Mandatory reporting for CPD non-compliance

Following implementation of the revised CPD Standard and Recertification requirements, both MBA and MCNZ will require annual reporting for CPD non-compliance. Please note that normal College internal processes for assisting overdue Fellows will continue. The CPD department is currently working with both regulatory bodies on future processes and further information will be available from the CPD webpage.

New Integrate CPD platform to replace My.RANZCOG

A new CPD platform is in development and will be available from 1 July 2022 when you sign into Integrate. The platform will provide improved dashboard, navigation, reporting and will be mobile friendly. More information will be circulated shortly with training webinar dates to be announced from the CPD webpage.

Summary

The landscape for CPD is no doubt changing, and from 1 January 2023 all medical practitioners in Australia will be able to choose their CPD home as stipulated by the MBA. The RANZCOG program is continually being updated to be responsive to the regulatory requirements and to assist Fellows in meeting them. It is hoped that members will continue to see the value in the RANZCOG program with the development of the new platform and supporting guidance and resources that will be available for the new cycle commencing 1 July 2022.

The CPD team is always available to assist you with any queries you have relating to your CPD at CPD@RANZCOG.edu.au.

Further reading

- Medical Board Australia, AHPRA. Strengthening Continuing Professional Development. Available from: www.medicalboard.gov.au/Professional-Performance-Framework/Strengthening-CPD.aspx.
- Medical Council New Zealand. Recertification and Professional Development. Available from: www.mcnz.org.nz/registration/maintain-or-renew-registration/recertification-and-professional-development
- RANZCOG CPD Framework, 2020. Available from: https://ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/CPD/CPD-Framework-September-2020.pdf

There's more than one 'C' in curriculum

Curriculum, Evaluation and Accreditation Unit, RANZCOG Education Directorate

What does it mean for RANZCOG when we say 'curriculum review'? The College offers a prevocational pathway, nine training programs, and equivalent specialist international medical graduate (SIMG) pathways for specialist and subspecialist programs. Each program comprises a complex mix of training, learning and assessment experiences, with accompanying processes, policies and regulations. 'Curriculum review', to put it mildly, covers a broad church.

The Curriculum Review Expert Advisory Panel (CREAP) was formed in 2018 to identify areas of specific focus for the College. Their report of mid-2019 established the main directions for curriculum review activities:

- Structure and design of College curricula
- Progression through programs to suit multiple career paths
- A move to more programmatic forms of assessment

The key College committee currently leading this work is the Curriculum and Assessment Steering Group (CASG), chaired by the College's Dean of Education, Prof Ian Symonds. They are supported by the Curriculum, Evaluation and Accreditation (CEA) unit of the College's Education Directorate.

While the challenges of COVID-19 have sometimes slowed the work of curriculum review since early 2020 (dealing with operational needs has often had to take priority), significant progress has nonetheless been made across a range of areas – the 'many Cs of curriculum' detailed below.

The timely implementation of the outcomes of curriculum review is vital ahead of the College's reaccreditation by the Australian Medical Council in 2023.

Contemporary – CanMEDS – Building for the future

The curricula of the College's Diploma and Fellowship programs (though not subspecialty programs) currently use three 'domains' to define competent obstetricians and gynaecologists: Clinical Expertise, Academic Abilities and Professional Qualities. However, the three domains in place cannot facilitate a full articulation of all key roles within any College curriculum, since role attributes or requirements become homogenised and not sufficiently represented.

The College is therefore adopting the CanMEDS Physician Competency Framework for all College training programs. First developed by the Royal College of Physicians and Surgeons of Canada in 1996, CanMEDS has become the most recognised and most widely applied healthcare profession competency framework in the world, used by medical colleges worldwide to identify and describe the abilities physicians require to effectively meet the healthcare needs of the people they serve.

Abilities are grouped thematically under seven roles, enabling a full articulation of what is expected of a qualified practitioner – the 'whole person' – and thus a comprehensive exploration of the breadth and depth of each training program:

- Medical Expert
- Communicator
- Collaborator
- Leader
- Health Advocate
- Scholar
- Professional

In the words of Prof Symonds, 'Adopting the CanMEDs framework will bring RANZCOG into line with what is recognised internationally in curriculum design for medical education and help us to place more emphasis on a patient-centred approach to professional development.'

Graduate Outcomes Statements

With the CanMEDS framework in place, the next step has been to develop a Graduate Outcomes Statement (GOS) for each training program. The GOS provides a high-level articulation of expectations to answer the following question:
'What should a qualified practitioner look like as they emerge from the program in ten years' time?'

The GOS is based around the CanMEDS roles, thus helping to flesh out the real person emerging from a program. It also incorporates a statement about scope of practice to identify the knowledge, skills and attributes a qualified practitioner will be expected to have attained upon satisfactory completion of training, in order to practise independently.

Each relevant College committee is refining a GOS to suit their program. The development of a GOS will ensure that the CanMEDS framework is adapted appropriately for each College training program, and with sufficient future-thinking to maintain its currency for a significant period. The GOS can then be used as the basis for a full review of curriculum detail.

> **'CanMEDS … tries to build a bigger picture for what constitutes essential aspects of a medical expert's profile, in order to provide a framework for medical training and education. RANZCOG … needs to integrate this conceptual change in medical education into its curriculum design in order to facilitate training and cultivate the whole aspects of a medical expert's profile in our future specialists.'**
>
> A/Prof David Shaker, CASG Member

Clarity and consistency – adopting a unified approach to curriculum structure

It is a challenge for any curriculum to explain in full the depth and breadth of required skills and knowledge at particular points in training. It is also a challenge to link skills and knowledge effectively. This becomes an issue when formulating examinations and other assessments and ensuring that they are fit for purpose.

In their July 2019 report, the CREAP identified a number of broad structural issues with current curricula, including:

- Conflicting information in different documents
- Basic and advanced learning requirements not defined in the FRANZCOG curriculum
- Inconsistent structures used for mapping assessments against key competencies, with no such mapping in subspecialty curricula.

To address these issues, a new standard curriculum structure design – known as Clinical Skills and Knowledge in Practice (CSKIP) – is to be applied across all College programs.

The CSKIP model provides a workable means of presenting learning outcomes and incorporating the necessary alignment with different stages of training, CanMEDS roles, teaching and learning strategies and assessment. It also shows the connections between each stage of training, and how knowledge is 'nested' within each stage – for example, knowledge acquired in early years is retained and extended in later years.

Prof Symonds suggests: 'Having a common "language" for our different training programs not only reduces duplication of teaching and assessment resources, but also opens up greater possibilities of recognition of prior learning, and facilitates movement between different career pathways in women's health within RANZCOG.'

Connection and cohesion – FRANZCOG Advanced Training

The previous decade or more has seen progressive shifts in approach to the two-year advanced training component of the FRANZCOG program. No specific requirements were in place prior to 2010, and in the period to 2016, there was a simple requirement that training included at least 50% clinical experience. 2017 saw the first articulation of Advanced Training Modules (ATMs).

The future of FRANZCOG Advanced Training provides a pathway for all trainees, no matter what their specific area of interest, while maintaining a common scope of practice for all those elevating to Fellowship.

The Advanced Training Pathway Framework (Figure 1) has been approved by the Education Standards Committee, and work is in progress to provide or refine the detailed requirements for each pathway. Of particular note:

- There will be a clearly-defined FRANZCOG pathway for each of the five subspecialties
- The introduction of a Sexual & Reproductive Health Pathway represents a major shift in addressing a key area in women's health

Critical judgment – examinations and assessment

Enhancing programmatic approaches to assessment

It is accepted in medical education that no individual assessment can determine whether a candidate is truly knowledgeable or competent. We can draw an inference about a trainee's true knowledge or competence, but this inference may be incorrect in some cases. Therefore, there is always a need to reduce the likelihood that:

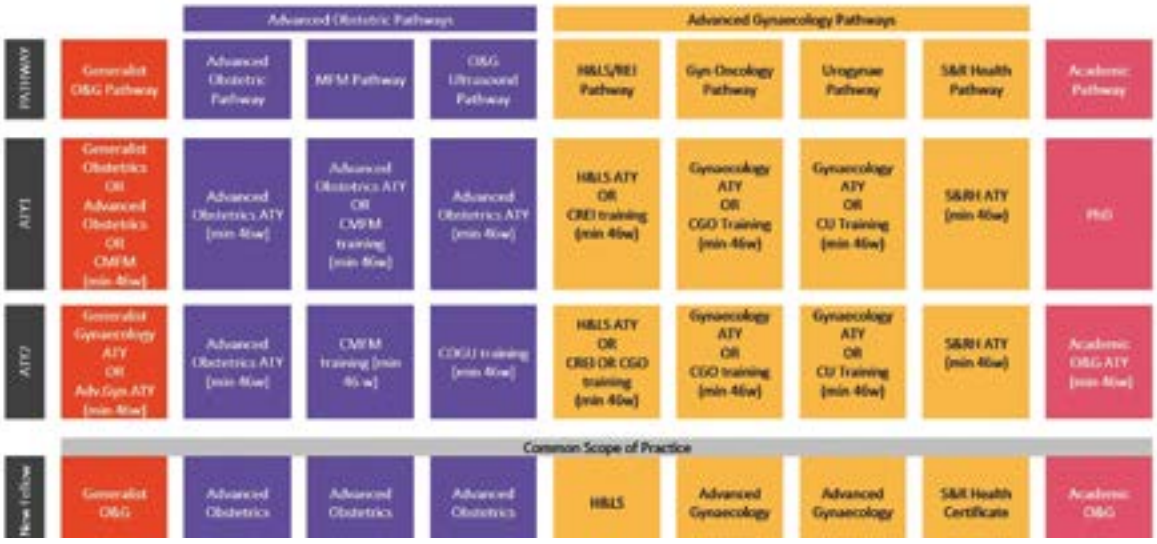


Figure 1. The Advanced Training Pathway Framework. ATY = Advanced Training Year.

- truly knowledgeable or competent candidates are judged as insufficiently knowledgeable or competent; OR
- truly unknowledgeable or incompetent candidates are judged as sufficiently knowledgeable or competent.

Modern medical education seeks to consider data from a program or suite of assessments in order to increase the likelihood of drawing a correct inference – hence programmatic assessment.

In reviewing assessment requirements for its programs, the College is investigating:

- Introducing a wider range of workplace-based assessments (WBAs)
- Improving the mechanisms behind training supervisor reports
- Ensuring a reliable and valid suite of examinations is used as a part of the program, though not necessarily as hurdle requirements

Prof Symonds once more: 'There is increasing recognition that obtaining a more rounded holistic view of trainee performance improves our ability to accurately and reliably judge whether trainees are ready to progress to the next stage of training or independent practice. We can best do this by moving away from a reliance on one single instrument or assessor, to gather feedback over time from different sources and then using this to make decisions on progression.'

Standard setting in examinations – the borderline approach

The concepts outlined above dovetail with a change in approach to examination standard setting.

There is a clear desire within the College to maintain a barrier role for examinations, but concern remains that current standard setting – which results in estimating a single point that is the pass/fail mark (in simplistic terms) – is unrealistic and unfair to some candidates.

2023 will see the phased introduction of a borderline approach to standard setting for College examinations. Clear passes will be identified at a point above borderline and clear fails below borderline. Candidates whose results fall between these boundaries will require further assessment – most likely through the use of increased WBAs and improved Training Supervisor reports as outlined above.

Communication

The vast majority of training takes place in a hospital setting, where trainees are supported by a range of consultants who provide feedback about their capabilities and competency. To reinforce the future of the College's training programs, particularly with the move to more programmatic forms of assessment, it is vital that all those involved in training are well-skilled in the provision of feedback. This will ensure trainees are supported to identify specific shortfalls in their performance as early as possible, enabling learning development plans and other mechanisms to be put in place to assist trainees address them before the assessment point.

Conduct – a note on bullying, harassment and discrimination

The College released the following statement in February 2022 in response to the publication of the report of the Bullying, Harassment and Discrimination (BHD) Advisory Working Group:
'Any form of bullying, harassment or discrimination is unacceptable, and poses a risk to employee and patient health and safety.

RANZCOG is concerned that so many of our members and trainees have reported gender bias, discrimination, bullying and harassment in the workplace. We regret that this has occurred and are sorry for any adverse impact it may have had on their lives. All our members and trainees deserve to work and train in a safe environment.

The independent Bullying, Harassment and Discrimination (BHD) Advisory Working Group report, which we have published today, commits us to action to help build respectful work environments.'

Through the curriculum review, and accompanying improved accreditation standards for training sites, RANZCOG will continue to try to ensure that zero tolerance for bullying, harassment and discrimination is ingrained in its culture, and that our future professionals are trained to demonstrate and model appropriate behaviours at all times.

> **'There is now international recognition that every moment of assessment, no matter how casual, is a powerful tool to aid learning by providing meaningful feedback.'**
>
> A/Prof Robert Bryce, RANZCOG Specialist Advisor: Assessment

Remembering Our Fellows

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

- **Dr Erica Kathleen Shellabear**, WA, March 2022
- **Dr Jonathan Mark Morling**, WA, March 2022
- **Mr Graeme Ralph Sharp**, NZ, April 2022

Clinical attachments for RANZCOG Diplomates

Dr Aggie Kujawa
GP Obstetrician
FACRRM, DRANZCOG Adv dip, MBBS

In preparing to write this article, I wrote to a small group of GP obstetricians (GPOs) and posed the question of what GPO upskilling should involve. To my surprise, I received 86 replies! Ongoing education and skill development is a hot topic. In this article I've attempted to reflect some of these views and ideas, while discussing what work as a rural GPO can be like, and the importance of maintaining and developing skills that are needed. There are currently no formal RANZCOG mandated requirements for upskilling in larger centres, although some states and hospitals have varying credentialling criteria for training through short-term placements.

I have spent the last three years working in Nhulunbuy, a mining town of about 3500 people in remote Northern Territory. Rural Generalists provide the medical services for our hospital, and there are normally two or three GPOs. We provide medical care for about 15,000 people living in the East Arnhem region. About 70% of our patients are Aboriginal people, and many live in remote communities. Antenatal care in the communities is mostly provided through Aboriginal Medical Services, and often remotely coordinated and reviewed by our hospital obstetric team. The women we care for typically have complex health needs, particularly due to a high prevalence of diabetes, kidney disease and rheumatic heart disease. As well as the burden of chronic health problems, good antenatal care is challenged by geographic, cultural and social factors. Some women have not seen a doctor in their pregnancy until they present to Nhulunbuy at term for their 'confinement'.

Our hospital is about 1000km from Darwin by road. We are supported by Careflight, but the limited availability of services as well as the sometimes-challenging weather conditions means that transfer times can be less that optimal. We manage low- to moderate-risk obstetric patients, with fabulous phone support from Royal Darwin Hospital, our referral centre. We help 150–170 women birth locally at our hospital each year and also coordinate the care of about 50 more high-risk women annually, planning for them to birth in Darwin. We also run a level 3 nursery which allows us to keep neonates and their higher risk mothers more often than some other small centres.

The purpose of this background is to paint a picture of the types of care that Diplomates in regional, rural and remote Australia are called on to provide. Sometimes we all have to deal with complex obstetric problems when transfer is not an option. Even though we have relatively small birth numbers to maintain our skills, we can be forced to manage unplanned, complex and high-risk situations, often with only one other GPO to call on for help. Our unit in Nhulunbuy is not alone in this – even those closer to tertiary facilities cannot avoid the unexpected complications or emergencies.

Some of the challenges that our team has had to deal with over the past three years include:

- a clinically unstable woman with a ruptured cornual ectopic with 3L blood loss
- a 27-week preterm birth
- more massive PPHs than I'd like to admit to, with management in the operating theatre, Bakri balloons and recently a B-Lynch suture
- caesarean sections for a fully dilated preterm breech birth, a massive Antepartum haemorrhage at 31 weeks and a transverse lie with ruptured membranes

In my first week of work in Nhulunbuy, I was called on to fly to a remote community to attend a woman at 31 weeks, septic and close to birthing. Because of a cyclone affecting the Darwin area, there was no option to send other paediatric or obstetric doctors. When I arrived with the retrieval nurse, the baby had been born and was being given respiratory support by a GP who worked in that community. The baby's mother was hypotensive, febrile and was bleeding with a retained placenta. Fortunately, we were able to manage this, using all the uterotonics in the Careflight kit, and performing a manual removal in that clinic, although without optimal pain management.

So how can we prepare ourselves for these situations? Practice scenarios can help, but I believe that clinical attachments in larger centres to upskill or refresh skills are vital to help maintain confidence, technical skills and to provide knowledge of policy changes and research developments. These attachments also enable growth in the communication and connection with the referral centre, which results in a better shared understanding of local systems from both ends. Improved relationships can lead to streamlining of referrals and management, and can ultimately lead to a decreased workload for referral centres and ultimately better patient care. While specific challenging births are unable to be planned during

a short placement, time in a larger centre can allow involvement in complex care with a specialist supporting and teaching. Previous experience is always helpful if emergencies have to be managed alone!

In the replies that I received from colleagues, many referred to a perception that GPOs normally manage low-risk births, and so opportunities for involvement in complex deliveries during upskilling terms were lacking or even deemed to be inappropriate and so not facilitated. Some GPOs report positive experiences, though others state experience in performing primary elective caesarean sections was provided, but the more complex situations like third or fourth caesarean sections, or even emergency operative delivery for a failed vaginal birth with full dilation, was managed by a consultant or senior registrar. Some reported not being able to do any more than assist at elective caesarean sections.

The responses that I have received overwhelmingly stated that enabling and expecting GPOs to take primary responsibility for complex deliveries during an upskilling placement was necessary to enable them to grow in their skills and abilities to manage in isolated centres. As well as this, having an opportunity to be involved in a relatively large number of births in a short time is important in reinforcing skills. To enable learning opportunities, being rostered with a senior registrar or consultant is vital. Experience with and learning new elective gynaecological procedures appropriate to the GPO's hospital is helpful. As well as skill development, the growing ability of GPOs from these placements can help to reduce unnecessary transfers and referrals to the larger hospital.

While upskilling terms are essential, arranging them can be difficult. Leave cover for small hospitals can be hard to arrange, and taking time away from home and family isn't easy for some GPOs. For Rural Generalist GPOs also needing upskilling in different specialties, arranging time away from their employing hospital for ongoing education is compounded. Shorter, more frequent upskilling posts when within driving distance for a GPO are useful options. Some GPOs struggle to find hospitals willing to support them, especially if larger centres only offer upskilling to those within their catchment area. This can particularly affect doctors working as locums, or those in areas where the referral hospital is unable to provide ongoing training. Lastly, some GPOs reported having to personally pay for an upskilling term in a larger centre, which put them at a financial disadvantage.

Despite these challenges, there are referral centres that take a very active approach to continuing education, with invitations to online departmental teaching and development of relationships. This can be particularly supportive of those GPOs who work as rural generalists involved in different specialties, who have limited time to keep up to date in each of those areas.

Upskilling in larger centres is vital to the maintenance of skillsets. In my view, support by larger centres and FRANZCOG colleagues of Diplomates working in isolated and challenging locations is necessary for ongoing patient safety, good obstetric management and coordinated care of vulnerable women.
The provision of clinical attachments needs the recognition and commitment that other onsite training is afforded.

GPO upskilling

Dr Judith Gardiner
MBBS(Hons), DRANZCOG(Adv)
Diplomate Board Director

> 'The capacity to learn is a gift; The ability to learn is a skill; The willingness to learn is a choice.'
> Brian Herbert

When I achieved my Diploma of Obstetrics in 1980 from the then newly incorporated Australian College of O&G (RACOG), having completed a six-month obstetric term and successfully passing my written and oral examinations, I did not feel adequately prepared to provide a full obstetric service in a rural location. The consultants, registrars and midwifery staff who led my training were fantastic, but six months is a very short time, even in a busy unit, to achieve not only competency but also confidence in the necessary skills. Hence began my long career in upskilling in obstetrics and women's health. There was no provision for extra obstetric training or supervision for GPs in Australia at that time, so, along with several other Australian graduates, I headed overseas to 'practise on the pommies' as their NHS provided a predominantly public health system where new skills could be learnt, and acquired skills improved and fine-tuned.

The DRANZCOG training supervisors and recent graduates that I speak to today tell a similar story, so that, despite the transition to a minimum twelve-months DRANZCOG Advanced training program, the reduced exposure to procedural training and the increasing litigious society has left new graduates in limbo, having learnt essential skills that are desperately needed in the extensive rural and remote areas of Australia, but feeling underprepared to venture into largely unsupervised practice. Even after my extended experience in the UK, I still keenly remember the panic I felt the first time I had to make the decision to perform an emergency caesarean section without having a higher authority to defer to. The decision was obvious (a brow presentation), but it was the sudden realisation that the buck stops here and that I was on my own.

Prior to 1989 there was no official requirement for GP obstetricians (GPOs) to engage in ongoing education or the accumulation of CPD points, and before the introduction of the Rural Procedural Grants Program in 2004 there was no financial assistance provided for GPOs to leave their practices to enhance their skills. The indemnity crisis in 2000 resulted in over 75% of GPOs ceasing intrapartum care, and Australia has failed to catch up since this loss, with ongoing closures of rural birthing units and a generation of rural overworked and under-resourced GPOs that will be difficult to replace with our new cohort of graduates who, rightly, expect a better work-life balance.

Upskilling for GPOs means having the opportunity to maintain, consolidate and improve core obstetric skills like performing caesarean sections and procedural deliveries, but also incorporates the learning of new skills that might fill a need in that practitioner's community, such as providing termination services beyond the first trimester or offering a colposcopy service.

It is imperative that urban and regional hospitals have an ongoing relationship with the rural units in their catchment area, that they offer new graduates extended supervised positions to help prepare them for rural practice and that they allow GPOs to attend their units for essential upskilling, especially in performing caesarean sections and procedural deliveries and managing obstetric emergencies. All units should invite the GPOs in their area providing intrapartum care to their regular M&M meetings, either in person or via video conferencing, as these meetings provide valuable opportunities to learn of the potential hazards of obstetric practice (and how to avoid them), and facilitates a healthy relationship within the obstetric team. Both DRANZCOG and FRANZCOG trainees achieve significant benefit from this interaction in understanding the unique needs and challenges of rural obstetric practice.

Many GPOs have had difficulty arranging hospital clinical attachments for upskilling. Many hospitals refuse requests for upskilling and others charge exorbitant fees to allow GPOs to 'work' on their maternity unit. Some regions do provide excellent upskilling opportunities with GPOs given the option of covering training registrars on leave or rural placement and reducing the need for locum registrars at that site. Unfortunately, most regional and urban hospitals do not currently have a program to engage GPOs.

There is currently no available assistance to arrange placements and GPOs are responsible for finding their own training sites. RANZCOG is working to improve this process by requiring FRANZCOG training sites to offer GP upskilling opportunities and by the roll out of our OGET project, where regional centres will be responsible for, and be provided with, government funding for ongoing obstetric training within their catchment area.

My personal journey in upskilling has incorporated the usual courses, workshops and conferences. ALSO, MOET, FSEP, Anatomy of Complications, PROMPT, Ultrasound and OASIS workshops are, or were, all invaluable for GPO practice. I have always attended M&M meetings where possible and always took the opportunity when assisting in gynaecological or obstetric surgery to pick the brain of the consultant I was working with. Upskilling hospital opportunities have provided excellent skills training and the opportunity to interact with the local team. I have assisted in my local regional hospital's public antenatal clinic and labour ward when staffing issues arise, and this has enabled me to enjoy a valuable association with the consultants and trainees in that setting.

Better engagement between regional and urban hospital birthing units and rural units in their area is essential to providing safe, optimal care for rural and remote Australian families. Where possible, low-risk pregnant persons should not have to travel long distances to access safe obstetric care with the associated risks of prolonged time away from home, family and local supports, and the very real concern of births occurring en route to the hospital. The unique skills and challenges of GPOs and midwives working remotely should be understood so that they remain well supported and provided with appropriate advice when required.

Learning as a GP never ends, and this is particularly true in the field of women's health. I am still constantly challenged by my patients, whether with the unique symptoms they describe, their individual response to therapy or their specific needs. Australia needs an ongoing GPO workforce.

O&G Education and Training (OGET) Program

OGET Project Team

A report by the Regional Australia Institute has indicated that more millennials (20–35 years old) are likely to look for opportunities in regional areas. The report classes regional areas as anything except the capital cities and indicates that approximately 1.2 million people moved into and around regional Australia based on data from the 2016 census. The primary drivers for young families to move to regions were identified as housing affordability, career advancement and better lifestyle opportunities. The report also noted that such movement contributed to the building of human and social capital within regional communities. Younger families moving into regional Australia also have expectations of adequate local medical services. Obstetrics and gynaecology form a central platform in any medical institution, or service, and are synergistic with other aspects of health delivery. The need to travel large distances to access medical services is not only time-consuming and expensive, but also separates people from their families and communities at a time when they are most vulnerable.

The maldistribution of the O&G workforce and the barriers to access to maternity care in rural and remote areas is well-documented by RANZCOG's workforce data, as well as through experience of our consumers and members. The data also identifies the lack of upskilling and training opportunities in rural and remote areas. The College has been in ongoing discussions with the Commonwealth Department of Health to develop a program and framework that enables health professionals in rural, regional and remote areas to avail upskilling opportunities. Following these discussions, the College is piloting the Obstetrics and Gynaecology Education and Training (OGET) program. The aim of this program is to deliver upskilling and education for a range of medical professionals who play a role in the provision of maternity or maternity-related services. A multi-disciplinary approach is imperative in delivering such a program, as many rural and remote areas are serviced by a broad range of health professionals.

How does it work?

The program will be delivered using a hub and spoke model, where the hubs provide onsite or outreach training to their peripheral hospitals in the form of case-based learning and interactive forums. The pilot will be rolled out to five hubs across Australia, with the hubs being selected by RANZCOG. It is estimated that each hub would service five to seven peripheral sites, enabling the program to cover close to 35 rural, regional and remote sites. A FRANZCOG or DRANZCOG employed at the hub hospital will be nominated to be the program lead for that hub. The program lead will liaise with RANZCOG and the peripheral sites to develop a training schedule. RANZCOG will develop and host content, and hubs will also be able to develop their own learning tools and resources, which will be shared across the program where applicable. The College will also provide program administration and governance, with oversight from the recently established OGET Steering Committee, who will provide strategic direction and guidance for the pilot. The program budget includes some salary support to cover the program lead's time, and a nominal allowance to support program administration at hub level. The budget also covers approximately two to three training days per site (the actual days will vary depending on hub and site capacity). The pilot will run for a year, concluding in February 2023.

How will the program be delivered?

The fundamental aim of the program is to deliver upskilling and education for a range of medical professionals who play a role in the provision of maternity or maternity-related services. The program will focus on case-based learning and case debriefs across a range of clinical scenarios. The case debriefs will also provide an opportunity for the group to undertake refreshers on the relevant systems and protocols applicable to each specific scenario. The case-based learning will be facilitated by the program lead either at the hub or through outreach. In addition to clinical skills, the training will also address other critical skills such as cultural competence, leadership, communication and people management. Such training will be delivered in a format as agreed upon by the program lead and RANZCOG.

What is the objective?

The pilot aims to gather evidence on the effectiveness of targeted training in rural and remote areas. The pilot also seeks to develop a framework for a sustainable model for maternity care in rural and remote areas through capacity-building and upskilling within local hospitals. Reporting and evaluation are built into the project requirements and will help identify further opportunities to improve the quality of education and training provided. The hub and spoke model will create networking and knowledge-sharing opportunities in rural and remote areas. A successful pilot will provide the foundations for a scalable and sustainable program that can be customised and replicated across a broad range of health settings.

In closing

Adequate health services underpin the success of every community and are the base upon which other services develop and thrive. In turn, this translates into economic, social and cultural benefits. Access to maternity care attracts young families and the

associated staff and support people. Supporting specialists, GP obstetricians, midwives, nurses and allied health staff through education and upskilling programs ensures that the quality of medical care remains at the highest standard. The absence of a consistent approach towards providing quality maternity care in these communities will result in fragmented and sporadic efforts towards upskilling and training of medical professionals. It will result in inconsistencies in the access, quality and standard of maternity care provided.

As the peak body for women's health in Australia, RANZCOG is well-placed to plan and implement this pilot. The expected outcome is an evidence base for the viability of a such an initiative in a larger format, and the development of a framework for a program that strengthens maternity services in rural, regional and remote Australia, supporting the people who care for their community. When done in collaboration with other important stakeholders across the different medical disciplines, this pilot will help in evaluating the merits of a consistent approach to upskilling and supporting medical professionals in rural, regional and remote Australia in delivering high-quality maternity care.

Further reading

- Bourne K, Houghton K, How G, et al. The Big Movers: Understanding Population Mobility in Regional Australia. 2020. Regional Australia Institute, Canberra.

Audit and the science of improvement

Dr Steven Lillis
MBChB, FRNZCGP, FAcadMEd, MGP, PhD
Medical Adviser
Medical Council of New Zealand

While most continuing professional development programs have a component of audit in them, its also fair to say that the audit creates a range of emotions, from despair (not another thing to do) to curiosity (I wonder what I can improve on). Further, there is some scepticism in the medical education literature about the effectiveness of audit in continuing professional development.[1] A Cochrane review on the effects of audit on clinical practice found small but potentially important improvements in clinical practice.[2] The authors did make what I think are crucial observations; the effectiveness is dependant on baseline performance and on how the feedback is given. This provides very useful guidance. Almost all of us as health professionals take great pride in doing our job well. Many of us will develop an area of interest (as a general practitioner, my area of interest is musculoskeletal medicine) and feel very comfortable in that area. If we are being honest with ourselves, we all have areas in which we are far less comfortable but often quietly ignore them. Yet these may well be the areas where we should be focusing our attention.

Evidence-based medicine is a cornerstone of medical practice. It doesn't dictate what we do but should always inform what we do. In much the same way, evidence-based education should be a cornerstone of education and continuing professional development. It can be defined as 'The conscientious and judicious application of best evidence to the design and delivery of medical education'. So, what does the evidence about audit reveal? An enlightening systematic review paper explored the evidence about how good we are at recognising our own learning needs.[3] The surprising answer is not very good. We rely on external information to monitor our standards; peer groups, meetings with colleagues and case discussions all provide opportunities where we might think 'I wasn't aware of that, and I think I should have been.' Audit also provides an external view on our knowledge and standards, but in a more formal way. It allows comparison of practice to a known and recognised standard. This is a critical part of choosing what to audit. There should be a recognised standard against which to judge ourselves. Audit with feedback is also significantly more effective for less complex professional behaviours than more complex. 'Discharge summaries need to be sent within 24 hours' is much more amenable to change than 'patient experience of the service needs improving'.

Improving practice as a result of undertaking an audit also requires that the feedback is structured correctly. In much the same way as providing feedback on clinical encounters, there are ways to maximise the effect of audit feedback.[4] Being aware that the person or team receiving feedback is in a vulnerable position is crucial and therefore addressing the barriers to receiving feedback becomes an essential part of the process. The generally accepted rules of feedback also apply to audit; it should be specific, focused on the task and not the person or team, given as close to the audit as possible and be objective and observational rather than subjective and value driven. It should also nurture reflection-in-action.[5]

A final point to make about audit is that there should be ways to make change. Publicly funded healthcare is notoriously underfunded, yet making change commonly takes resources and commitment beyond what an individual or team can do or take responsibility for. It becomes important to think at the proposal stage of an audit 'What might the results be and what changes are possible if the audit indicates change should be made?' This also avoids the pitfall of time spent on audit as simply a method of satisfying CPD requirements and positions the audit as something from which change will likely happen.

A particularly useful role of audit over recent years has been to look at issues of equity in healthcare. These audits have drawn attention to disparities in health outcomes for Māori in Aotearoa as well as Aboriginal peoples and Torres Strait Islanders in Australia. Audit in this area has proved a valuable tool not only to reveal avoidable inequities but also to monitor progress. Because data on ethnicity is relatively easy to collect, comparison groups are already built into data collection in many electronic records.

Audits vary widely in structure, function and complexity. No single audit tool will suffice. Using audit tools previously developed does make the task of designing audit much easier and many only need minor adaptation. The Queensland government maintains a useful site with a variety of audit tools and some well written 'how to do an audit' information.[6]

An old but still influential literature review on audit in medical practice found that training in method of audit, protected time to undertake the work, adequate resources and a clear structure of what will happen were important factors for success.[7] Problems that can emerge and that can derail the process were diminished clinical ownership, litigation fears, professional isolation and power struggles. When done correctly, there was better communication amongst colleagues and between healthcare teams, improved patient care, better administration and increased professional satisfaction. These are worthy goals.

Full Reference list available online.

Accreditation: a vital function

Curriculum, Evaluation and Accreditation Unit, RANZCOG Education Directorate

Why do we accredit training sites?

RANZCOG is accredited by the Australian Medical Council (AMC) and the Medical Council of New Zealand (MCNZ) to deliver education and training programs to doctors throughout Australia and Aotearoa New Zealand in the specialty of obstetrics and gynaecology. Under the AMC standards, the College must in turn have clear processes and criteria to assess, accredit and monitor training sites.

Accreditation activities allow the College to get a view of training exposure and opportunities available at an accredited site, as well as a sense of the working environment and culture. This ensures that the key requirements for clinical and education experience are being met. A/Prof Deryck Charters, the College's Specialist Advisor: Accreditation, suggests that 'accreditation also has an important role in ensuring that the consumer can be confident that trainees are getting the training and experience necessary to best service the communities in which they work'.

Accreditation also performs a vital function as a support mechanism for training sites across Australia and Aotearoa New Zealand. By ensuring training sites are driven to meet the accreditation standards, opportunities arise for the College to support O&G units in raising concerns with their hospital executive, in areas including availability of theatre lists, staffing needs, engagement with multidisciplinary teams, and workplace culture, thus providing a platform to improve training and advocate for improved services simultaneously.

Accreditation standards and processes

Accreditation standards provide an agreed-upon template to ensure there are overarching rules and guidelines that are applicable to all sites, while taking into account differences in size, patient acuity, and available education and training experiences. For example, the FRANZCOG Training Program considers the following standards necessary for the provision of effective training and support for trainees in the program:

- Support for RANZCOG Officers and engagement with hospital accreditation processes.
- Appointment and support of Training Supervisors.
- Consultant involvement with and support for FRANZCOG trainees.
- Provision of clinical supervision and experience.
- Provision of structured education programs, teaching sessions and learning opportunities.
- Workplace culture, registrar staffing, safe working hours, leave arrangements and assistance for rural rotations.

Each subspecialty program requires that an accredited unit (which can be made up of several sites in different locations) is able to provide training consistent with the expectations outlined in the handbook for each individual program. Development of a revised set of subspecialty accreditation standards is planned in 2022.

FRANZCOG accreditation is based around a site visit, with follow-up progress reports and further visits as required. Oversight of FRANZCOG accreditation activities is the responsibility of the College's Accreditation Steering Group (ASG), with matters arising handled by the Chair of the Training Accreditation Committee and the Specialist Advisor: Accreditation. Reaccreditation of subspecialty training units utilises a hybrid paper-based and accreditation visit model to ensure ongoing monitoring across each program, and is carried out in conjunction with the Accreditation Advisors appointed by each Subspecialty Committee.

Each accreditation visit is conducted by an Accreditation Panel, usually comprising:

- A RANZCOG Fellow/subspecialist as the Panel Chair, plus an additional Fellow/subspecialist as required.
- A trainee representative (FRANZCOG site visits).
- One or more senior members of RANZCOG staff, responsible for the administration of the accreditation process.

In order to determine an outcome and appropriate period of accreditation, confidential interviews with all available trainees, Fellows, Training Supervisors, consultants, Heads of Service, and any other relevant health professionals are carried out. This supplements situational analysis information gathered prior to the reaccreditation visit in the form of a hospital questionnaire, anonymous surveys (for current/recent trainees, Training Supervisors, and consultants), information from the State/Territory/New Zealand Training Accreditation Committee or subspecialty committee, and procedure number data. Accreditation therefore acts as a snapshot of a site at the time of a reaccreditation visit.

Recommendation 11: RANZCOG strengthens the accreditation requirements for hospitals and O&G departments to demonstrate what they proactively do to create a safe and effective workplace free from DBSH and address DBSH when it arises.

Recommendation 12: As part of the accreditation cycle, RANZCOG requires training sites to provide evidence that they conduct annual 360-degree assessments of heads of department, clinical directors, training supervisors and consultants who train trainees, and take appropriate action on the results of the assessments.

Recommendation 20: RANZCOG strengthens links with and reporting to training sites and other hospitals. RANZCOG signs memoranda of understanding with hospitals, which affirm a joint commitment to dealing with DBSH, sharing information and collecting data on complaints. RANZCOG reflects these provisions in its accreditation standards for training sites.

RANZCOG collates data on the prevalence of DBSH by individual workplace so that interventions can occur when identified and appropriate.

Where a workplace or regulator shares information with RANZCOG on validated concerns or complaints, the RANZCOG Training Accreditation Committee considers whether the training site is safe. In serious cases, the College considers the withdrawal of accreditation until the site is demonstrably safe. Where data or reports identify serious or repeated issues with particular College members, the College considers action under its Code of Conduct in relation to the member(s).

Figure 1. Excerpt from *Bullying, Harassment and Discrimination Advisory Working Group Report to the RANZCOG Board 'From Advocacy to Action'*.[2]

Key focus: bullying, harassment and discrimination

The results of AHPRA's 2021 Medical Training Survey (and those from previous years) highlight how critical the role of accreditation is in addressing the prevalence of bullying, harassment, and discrimination (BHD). Dr Hashim Adbeen (Chair, AMA council of doctors in training) recognises college accreditation of training sites as 'ultimately a patient safety issue' and advocates for strengthening accreditation standards.[1] Following an independent, confidential, and anonymous survey of all members and trainees conducted in the second half of 2021, the College's BHD Advisory Working Group delivered a report to the RANZCOG Board in February 2022 with 24 recommendations. Of these, Recommendations 11 and 12 are specific to the accreditation process while Recommendation 20 centred around additional provisions in the accreditation standards with regards to complaint handling.[2] (Figure 1)

Accreditation is recognised within the report as one of the most powerful 'hard levers' available, and represents an action that the College can take directly to respond to unprofessional behaviours in O&G. Actions and activities addressing these recommendations will form core tasks for the ASG and others involved in accreditation improvements throughout 2022.

Accreditation interventions: how accreditation can address issues arising

The normal processes and mechanisms used for accreditation (such as hospital questionnaires, trainee surveys, site visits reports necessarily identify and address training site issues at the time these processes are used. However, at other times, the accreditation team may be alerted to potential issues in a range of other ways; for example, formal complaints, trainee feedback via six-monthly assessment surveys, the Training Support Unit or regional offices, Fellow feedback through committees or direct conversations with the President. Recognising the need for support mechanisms outside of a standard accreditation cycle, the Accreditation Interventions Framework was developed and introduced in 2020 to more immediately support both trainees and training sites in addressing specific or urgent issues as they arise.

Where an accreditation visit is not already scheduled, the Interventions Framework provides a number of options in order to address the area(s) of concern, from a simple letter to the training site requesting a response to the stated issue(s), to a Situational Analysis Report comprising the information requested prior to conducting an accreditation visit. An actual visit may then be required after reviewing responses.

This framework allows for an array of training-related issues to be addressed promptly rather than being left to fester for the remainder of an accreditation cycle, and has been used to great effect alongside standard accreditation processes as a driver for positive change and increased support.

Gynaecological surgical training: putting the 'G' back in O&G

There is an imbalance in access to gynaecological surgical training, depending on training site and location, affecting both FRANZCOG and subspecialty trainees. The effects of the COVID-19 pandemic, with lockdowns, elective surgery cancelled in some jurisdictions, and ongoing strain on hospital staff dealing with the Omicron variant, have exacerbated the existing issue of how trainees can receive adequate gynaecological surgical training and meet their training requirements.

A significant amount of work has been undertaken in the accreditation space over the last two years to address this issue. *Guidelines for gynaecological surgical training* have been developed, which re-emphasise the number of opportunities that must be offered by different types of training hospital, together with accreditation mechanisms to address underperforming sites. Perhaps more important is the accompanying document *Strategies for Training Hospitals to Improve Trainee Gynaecological Surgery Procedure Numbers,* supporting O&G units to achieve better outcomes for trainees.

Accreditation and COVID

Accreditation was not unaffected by COVID-19, with the pandemic necessitating the development and implementation of virtual reaccreditation visits. The use of Zoom and other videoconferencing technology has allowed reaccreditation visits to continue, with 31 virtual visits conducted since July 2020. While some aspects of a virtual reaccreditation visit differ from their physical counterpart by necessity (the opportunity to conduct interviews in person, tour training sites, and share a meal with colleagues remain sorely missed), robust information gathering and clear standards ensure the continued integrity of the process.

How can you help?

The accreditation process is made possible by the Fellows and trainee representatives who volunteer their time to contribute to training. Not only do they attend visits and conduct interviews, but they also review and contribute to reaccreditation and progress reports and share their wealth of medical education and training knowledge throughout Australia and Aotearoa New Zealand. Panel members report finding the experience valuable as an opportunity for reflection and providing insight into best practice across other training sites. Fellows have the ability to claim CPD points under the Educational Activities (EA) domain for any RANZCOG Accreditation Visit where they form part of the Accreditation Panel.

For further information about accreditation, or to be included in the mailing list for future visits, please email accreditation@ranzcog.edu.au.

References

1. John W. Bullying in medicine: the biggest losers. AU: Medical Republic; 2022. Available from: medicalrepublic.com.au/bullying-in-medicine-the-biggest-losers/62475
2. RANZCOG BHD Advisory Working Group. Report to the RANZCOG Board: From Advocacy to Action. Melbourne, VIC: RANZCOG; 2022. Available from: ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Member%20services/Wellbeing/BHD-Advisory-Working-Group-Report-to-the-RANZCOG-Board.pdf

Planting the seeds for surgical coaching

A/Prof Martin Richardson
Orthopaedic surgeon, Epworth Hospital, clinical school University of Melbourne
Surgeon Commander, Royal Australian Navy

Do surgeons need coaches? But I thought coaches were for sports teams, and possibly for high-flying corporate executives. This is an interesting question contested in a 2011 article in *The New Yorker* by the noted author of *The Checklist Manifesto* and *Complications*, general surgeon, Atul Gawande.[1] Atul challenged all coaches and described his success in recruiting his own surgical coach to his surgical potential.

What is coaching?

Many people confuse coaching with parallel activities such as teaching, mentoring and counselling. A simplistic distinction of coaching from these other activities can be summarised as 'asking rather than telling'. A coaching interaction is a non-judgemental conversation between coach and coachee fuelled by curiosity[2,3] and driven by effective questioning and deep listening.[4]

What are the benefits of surgical coaching?

Published results of the benefits of surgical coaching are still thin on the ground. The impact of coaching on improving the results of Michigan Bariatric Surgical Collaborative are impressive.[5,6] Greenberg and her colleagues have demonstrated the efficacy of surgical coaching through their Wisconsin based Academy of surgical coaching.[7,8] Louridas et al, in a recent systematic review of coaching in surgical education, has established criteria to encourage further research into surgical coaching and how it fits with other parallel activities such as teaching and mentoring.[9] This may be the fertile opportunity for research with enthusiastic registrars and consultants.

One surgeon's coaching journey so far

In 2012, I was invited to Zurich to attend a workshop run by the AO Trauma organisation who have been providing world-leading surgical education for over 60 years. I was selected to be one of the newly created members of the regional education trainers (RET) within our Asia Pacific region, one of five regions in the AO world who also sent members from each of the other regions to be upskilled by PhD educators to facilitate the development of the teaching faculties around the world. After a very enlightening education workshop, we were sent on our return journey with homework to read Gawande's article. This started me thinking about this novel concept of coaching for proceduralists.

How good or bad is our current CPD?

I reflected on the issues raised in this article and thought that overall, our registrar training in Australasia was likely to rival the best in the world. Unfortunately, after passing our exit exams as surgeons, the CPD process lacks rigor and to me is essentially a tick-box exercise. Could coaching provide an avenue to address this shortfall? I noticed that my orthopaedic colleagues in New Zealand were required to be involved in the NZOA Practice Visit Programme since 2012[10,11] The New Zealand general surgeons followed a similar program in 2020. While innovative, this seemed to lack one critical element – training of the observer in the skills of feedback. I wondered could this be enhanced by some training in this key facet and possibly even more so by a coaching mindset?

Should coaching become part of our hospital accreditation?

The current hospital accreditation process is essentially a tick box activity with little future planning. Could coaching be recommended as the process for taking the current audit processes to begin to develop a culture of continuing improvement within our hospitals? Most surgeons and O&Gs operate in a vacuum with little oversight or opportunity to get a fresh set of eyes on the way we practice. This leads to stagnation of our abilities and practice. A coaching mindset would allow a fresh look at how we approach clinical issues and allow us to develop goals of self-improvement, ultimately improving the outcomes of our patients.

This cultural and mindset change will also benefit our trainees and medical students in their education and mastery of our fields. Introduction of innovations such as robotic-assisted surgeries and similar technological changes would also be facilitated by a coaching approach. If we could encourage the medical indemnity insurers to fund the research to demonstrate the benefits of coaching, this may be reflected favourably in our insurance contributions.

Surgical education and feedback skills

Following my trip to Zurich, my teaching of registrars, medical students and fellows took a significant leap forward with the new feedback skills learnt. My appetite had been whetted and I sought out the newly released Masters of Surgical Education program offer conjointly with the RACS and University of Melbourne. I met several like-minded surgical educators, including some O&Gs. The

science of education was fascinating, and my skills developed further as I learnt and understood more and more about the theories of adult education.

What can we learn from the defence forces?

As a member of the Royal Australian Navy (RAN), I have had the privilege of experiencing high-quality leadership training. On the back of a number of leadership workshops, I have been offered some one-on-one coaching within the Directorate of Navy Culture.[12] Finding this an enlightening experience and noting the lack of formal leadership training within civilian health, I began to reflect that this was a missing element in this sphere of my life.

Coach training

In December 2019, my Christmas present was to be asked to join the professional coaching group within the RAN, having completed my level 1 & 2 coach training with the Institute of Executive Coaching and Leadership. Soon after I became time rich with the impact of CoVid, and many surgical lockdowns inflicted on our elective surgical practices. I was able to invest this time in coaching some wonderful emerging leaders in the RAN. Inspired by this, I enrolled in a Masters of Coaching Psychology at the University of Sydney. My studies have introduced me to the world of research that underpins the art of coaching and has bolstered my coaching practice.

Do surgeons need coaches?

Returning to my original lightbulb moment inspired by Gawande, who had gone out and sourced his own surgical coach, I began to search for other examples of this. I discovered that an Academy for Surgical Coaches had been established in Wisconsin, USA, by a number of enlightened surgeons, including some O&Gs. It offered a four-hour training program, which I undertook in 2020.

A good framework to start coaching

Sir John Whitmore offered us a simple but effective framework to base our coaching, the GROW model.[13] This starts with goal setting (G) then assessment of the current reality (R) establishing a gap to work on with the coach. All the potential options (O) are then considered before establishing what will (W) happen in an action plan to achieve these goals. Coaches will also add accountability to the coaching relationship. I see true CPD involving an O&G surgical coachee setting their learning goals for the year and then working with their coach to develop a plan to achieve these CPD goals.

How can we acquire and develop some coaching skills?

For O&Gs and surgeons interested in experiencing what surgical coaching may offer, the Academy of Surgical Coaching have a four-hour virtual basic surgical coach training at $1000 USD (surgicalcoaching.org). There is a local surgical coach training program in development at Monash University that will provide some local training soon.

Video based or face-to-face?

A case can be made for both direct observation and video-based coaching. The former is quite time consuming for the coach and possibly distracting for the coachee. Video-based capture of endoscopic footage of camera based in the surgical lights or GoPro camera have been described. The latter is more time efficient for the coach along with a Zoom coaching session after watching the recorded surgical procedures with snippets used to provide curious coaching. Some ethical issues may need to be addressed within each hospital setting but should fall under the privileged gamut of similar audit processes. Depending on the coachee's needs, expert coaching or peer-based coaching models have been described. Some would say a coach doesn't even need to be in the specialist field and may be able to ask more probing curious questions from a place of relative ignorance.

The challenge

I would like to conclude with a challenge to all surgeons that aspire to being the best they can be. Sir John Whitmore summarised coaching in a simple equation,

Performance = potential – impediments[13]

To achieve this, a surgeon needs help to uncover blind spots and be held accountable by their coach who has helped them develop challenging SMARTER goals that will progress them closer to their ultimate potential, thus maximizing the outcomes for their patients and benefiting their profession within a better health system.

Coaching checklist

1. Make the decision you would like to improve
2. Find a coach
3. Commit to goals and ground rules at first coaching conversation
4. Capture some operative video footage
5. Arrange coaching sessions to review this
6. Consider training to become a surgical coach

Suggested Resources

- Podcasts
  - Gynaecologic surgeons unscrubbed[14]
  - Deep listening[15]
- YouTube and TED talks
  - Want to get great at something? Get a coach[16]
  - How leaders can avoid the advice trap. The future of work[17]
- Books
  - Coaching for Performance: The principles and practice of coaching and leadership[13]
  - The Coaching Habit: Say less, ask more and change the way you lead forever[2]

References

1. Gawande A. Personal Best: Top athletes and singers have coaches. Should you? *The New Yorker.* 2011.
2. Bungay Stainier M. The coaching habit: Say less, ask more and change the way you lead forever. Box of Crayons. 2016.
3. Bungay Stainier M. The advice trap: Be humble, stay curious and change the way you lead forever. Box of Crayons. 2020.
4. Trimboli O. Deep listening: Impact beyond words. oscartrimboli.com. 2017
5. Pradarelli JC, Hu Y-Y, Dimick JB, Greenberg CC. The Value of Surgical Coaching Beyond Training. *Advances in Surgery*. 2020;54:31-47. doi.org/10.1016/j.yasu.2020.04.003
6. Shubeck SP, Kanters AE, Sandhu G, et al. Dynamics within peer-to-peer surgical coaching relationships: Early evidence from the Michigan Bariatric Surgical Collaborative. *Surgery*. 2018;164(2):185-8. doi.org/10.1016/j.surg.2018.03.009
7. Greenberg CC, Ghousseini HN, Pavuluri Quamme SR, et al. A Statewide Surgical Coaching Program Provides Opportunity for Continuous Professional Development. *Ann Surg*. 2018;267(5):868-73. doi.org/10.1097/SLA.0000000000002341

Full Reference list available online.

Understanding health literacy in practice

Dr Penelope Fotheringham
BMedSci, MBBS(Hons), MPH, MSc(ID), FRANZCOG, FAFPHM
Faculty of Health and Medicine,
The University of Newcastle

Dr Edwina Dorney
BAppSc, MBBS (Hons), MPH
Central Clinical School,
Faculty of Medicine and Health,
The University of Sydney

Dr Tessa Copp
BA (Hons), PhD
The Sydney Health Literacy Lab,
Sydney School of Public Health,
Faculty of Medicine and Health,
The University of Sydney

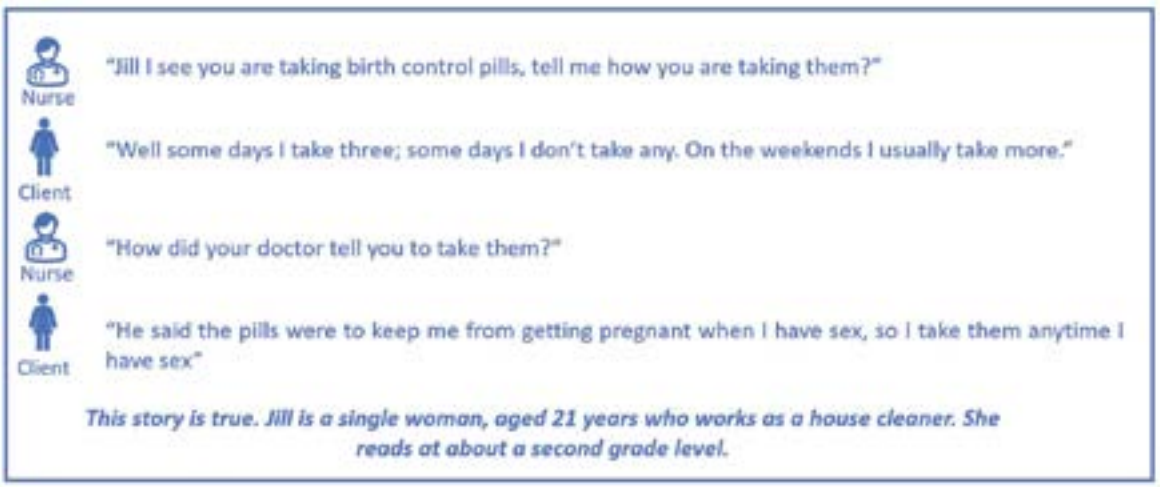
What is health literacy and why is it important?

Health literacy can be defined as 'the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions'.[2] It extends further than the ability of the individual to read patient information, access health information electronically or to follow instructions that they are given. It also includes the capacity of the individual to make decisions in their personal context to promote their health needs and the needs of their society, increasing their autonomy and empowerment (Figure 1).[3] The relationships between reading ability (literacy) and health literacy, health literacy and electronic health literacy are complicated and not reciprocal.[4]

It is estimated that 44% of Australian adults have low literacy levels and read to 'Level 1 to 2', with Level 1 being primary school and Level 2 equivalent to Year 10 and below.[5] National surveys of health literacy in Australia have shown that less than half of respondents (39%) understand health information well enough to know what to do, and only one in three respondents described being always able to actively engage with healthcare providers.[6]

Levels of health literacy impact on the individual and their interactions with the healthcare system.[7] People with lower health literacy are more likely to have worse health outcomes overall with higher rates of chronic disease, hospitalisation and mortality.[8] Lower levels of health literacy are associated with lower education levels, lower socioeconomic status, minority gender and sexual identity groups, increased age, and those from culturally and linguistically diverse (CALD) backgrounds. These are commonly referred to under the umbrella of 'the social determinants of health' and may contribute to the health inequality that is experienced by clients with these characteristics.[9,10] In contrast, higher levels of health literacy are associated with increased patient involvement in shared decision making, and better health outcomes. The national survey demonstrated that higher levels of health literacy correlated with younger age, decreasing remoteness of residence, and increased education, participation in ongoing learning, being employed and increased technicality of employment.[6]

It is important to note that there is limited data on health literacy levels in Indigenous Australians and people from CALD backgrounds, with available data suggesting lower health literacy levels in these groups.[11,12] Both the Indigenous and CALD communities want to be involved in their healthcare and decision-making processes, but often lack the understanding to effectively do so.[13] Patterns for understanding health literacy



Case study image. Adapted from Graham and Brookey[1]

levels in the Indigenous and CALD populations are complex and involve consideration of age, gender, socioeconomic status and health status.[11]

The emphasis on patient-centred care and shared decision making underpins our modern approach to healthcare. The importance of understanding health literacy in this context is highlighted in Table 1, illustrating that low health literacy decreases patient autonomy and empowerment, limiting the capacity of delivery of person-centred care.[14]

How is health literacy different in sexual and reproductive health?

Health literacy in the domain of sexual and reproductive health (SRH) 'goes beyond knowledge and behaviour and is the self-perceived ability of an individual to access the needed information, understand the information, appraise and apply the information into informed decision making for a good way to contribute to sexual and reproductive health.'[16] The World Health Organization discusses SRH literacy in the context of fertility planning and contraceptive access, sexually transmitted infections, relationships and domestic violence and gender inequality.[17] Autonomy in these areas allows an individual, especially a woman, to be able to improve their health and place in society and correlate with multiple Sustainable Development Goals.[17] Sexual and reproductive healthcare is thus an area where the social determinants of health are highlighted due to the status and rights of women internationally. Internationally, women are more likely to be poor, uneducated, victimised by culture, religion or government policy, subject to food and financial insecurity, lack autonomy and be marginalised in societies – thus have less social capital to gain their human right to basic healthcare.[18] These situations create and perpetuate poor health literacy, yet in their life course all women will have significant health needs that require greater than functional health literacy to access and navigate healthcare providers and services.

Research on the relationship between health literacy and women's reproductive health has shown that low health literacy has a negative effect on women's health knowledge and engagement in preventative behaviours and impacts their ability to navigate the health system and care for their children.[19] Using fertility planning as an example, low health literacy is associated with less understanding of menstrual cycle physiology, mechanisms of pregnancy, purpose and use of contraception, and a potential association with unplanned pregnancy.[20] Women with low health literacy are also more likely to not understand instructions regarding contraceptive use[21] and how to modify use and sexual behaviour when it is incorrectly used.[22]

What are the impacts of low health literacy and what can we do?

The consequences of low health literacy are far reaching and impact individuals and their families, the health system and may have medico-legal implications for the healthcare provider regarding their duty of care and consent of clients. If the healthcare worker is unable to accurately identify the client's level of health literacy, and thus their capacity to be involved in the consultation process, then they will not respond appropriately to their client's need. The result of this is that they will not offer an appropriate level of care, engage in the delivery of patient-centred care, or be able improve the health status through effectively offering preventative measures.[23]

Health professionals usually have an awareness of health literacy but often misjudge the health literacy level of the individual, as well as overestimating their communication skills.[24,25] Factors such as limited consultation time also constrain the ability to cater for individuals and their needs.[26] Routine measurement of the client's health literacy is not recommended as it has not been shown to improve patient outcomes. This is in part due to inaccurate measurement and classification, and as it is not a static characteristic.[25,27-29] Thus the concept of 'health literacy universal precautions' is important as it can improve care for all patients through the assumption that every patient has difficulty understanding information in a medical consultation.

The Australian Commission on Quality and Safety in Healthcare recommends that universal health literacy precautions be employed in both the consultation with an individual patient, and the environment or health system that they need to access.[30] Things to consider for your practice environment include factors at the individual and organisational level as shown in Figure 2.

Strategies for individual client consultations include the use of plain, jargon-free language and adopting methods to ensure client understanding such as the 'teach-back method'.[29] This technique involves having the client teach back to the clinician the key information and messages conveyed within a consultation. Assuming that a patient understands without checking comprehension leads to a mismatch in clinician-client communication. The teach-back

Classification of health literacy and relationship to self-autonomy and empowerment		
Functional literacy	An adequate level of basic literacy (reading and writing) skills to allow functioning in day-to-day life.	Less autonomy and empowerment ↓ Increasing autonomy and empowerment
Interactive literacy	A more advanced level of literacy and social skills to allow participation and interaction in day-to-day life. To extract and understand information from an interaction. To apply this new information to another situation.	
Critical literacy	A more advanced level of literacy and social skills to allow appraisal of new information. The ability to use this information to have control in one's circumstances.	

Figure 1. Classification of Health Literacy (adapted from Nutbeam et al)[15]

Figure 2. Health Literacy Universal Precautions.

method can be applied by all staff within a health service, both clinical and non-clinical, so that patients can navigate health locations, appointments, and consultations better. Using other tools in conversation, such as the Conversational Health Literacy Assessment Tool (CHAT) recommended by the Clinical Excellence Commission, will give healthcare providers a way to ask about facets of health literacy if this has not previously been part of their practice.[31]

Consideration should also be given to any patient information. This includes information on medical conditions, treatment options and associated risks, and available services. Readability of patient materials is often at a higher literacy level than patient capability and evidence suggest that less text can lead to improved understanding.[32,33] A balance between the need to convey relevant clinical information with a consideration to an individual's information capacity must therefore be met. Using the strategies above, information can be delivered in a manner that empowers the patient through improved understanding of their health.

Strategies at an organisational level include ensuring health services are easy to find, access and navigate. Ultimately, the health literacy of Australia's priority populations can only be improved by addressing the wider social determinants of health.[3] This begins with strategies to improve the way priority populations access their health information. The use of mainstream and culturally specific media channels can increase the reach of health information. Additionally, available health information must be reliable, trustworthy, culturally appropriate, and easy to understand. For our Indigenous and CALD populations, this information should be led by their community and disseminated under community guidance. These simple measures will build environments where individuals can be actively involved in decisions about their own health and contribute to collective action to improve the health of their community.

Patient-centred care and shared decision making are two principles that underpin our healthcare system. Health literacy is directly correlated with a client's autonomy and empowerment. We cannot assume that all individuals have a satisfactory health literacy to achieve this. It is our responsibility as healthcare providers to enable an environment that recognises individuals with low levels of health literacy and empower them to participate in decisions about their healthcare. Adopting the universal precautions for health literacy will increase compliance, improve outcomes and the overall healthcare of individuals, communities and the wider population.

References

1. Graham S, Brookey J. Do patients understand? *The Permanente Journal*. 2008;12(3):67-9.
2. Ratzan S, Parker R. Health literacy. National Library of Medicine, Current bibliographies in Medicine Bethesda: National Institutes of Health, US Department of Health and Human Services. 2000.
3. Nutbeam D, Muscat DM. Health Promotion Glossary 2021. *Health Promotion International*. 2021;36(6):1578-98.
4. Monkman H, Kushniruk AW, Barnett J, et al. Are Health Literacy and eHealth Literacy the Same or Different? *Stud Health Technol Inform*. 2017;245:178-82.
5. Australian Government. Style Manual, Literacy and Access. 2021. Available from: stylemanual.gov.au/accessible-and-inclusive-content/literacy-and-access.
6. Australian Bureau of Statistics. National Health Survey: Health literacy 2019. Available from: www.abs.gov.au/statistics/health/health-conditions-and-risks/national-health-survey-health-literacy/latest-release.
7. Peerson A, Saunders M. Health literacy revisited: what do we mean and why does it matter? *Health Promot Int*. 2009;24(3):285-96.
8. Berkman ND, Sheridan SL, Donahue KE, et al. Low health literacy and health outcomes: an updated systematic review. *Annals of Internal Medicine*. 2011;155(2):97-107.
9. Kickbusch I, Pelikan J, Apfel F, Tsouros A. Health Literacy: the Solid Facts. Geneva: World Health Organization; 2013.
10. Marmot M, Allen JJ. Social Determinants of Health Equity. *American Journal of Public Health*. 2014;104(S4):S517-S9.
11. Beauchamp A, Buchbinder R, Dodson S, al. Distribution of health literacy strengths and weaknesses across socio-demographic groups: a cross-sectional survey using the Health Literacy Questionnaire (HLQ). *BMC Public Health*. 2015;15(1):678.

Full Reference list available online.

Psychological safety: what's the big deal?

Dr Christina E Johnson
MBChB, FRACP, PhD
Director, Monash Doctors Education,
Consultant in General and Geriatric Medicine,
Monash Health
Adjunct Clinical Associate Professor,
School of Clinical Sciences, Faculty of Medicine,
Nursing and Health Sciences, Monash University

Modern healthcare involves clinicians partnering with patients to deliver individualised care in a fast-paced environment. Institutions everywhere seek to provide consistent, high-quality care. Yet these complex systems are quite different from machines in a factory producing standardised widgets. One major distinction is the central role of people working in teams; individuals with different functions that need to work together. In recent years there has been an increasing focus on the key determinants of a high performing team. To most people, it is surprising that psychological safety has repeatedly been at the top of the list, as opposed to individual excellence, clear protocols or team training (although, clearly, each of these is useful). The psychologist Amy Edmondson, now based at the Harvard Business School, was a pioneer investigator into the factors influencing team performance and has championed the fundamental role of psychological safety in both healthcare and beyond.[1,2] In the business world, Google instigated 'Project Aristotle' to clarify the key characteristics of their top performing teams. It took them a while to label the 'missing factor' but once they had identified it as psychological safety, they reported it was the single strongest influence on performance.[3] So why is psychological safety so important?

Optimal team performance hinges on making the most of everyone's potential value. This is not just the sum of separate inputs. It is about collaboration – how members 'value add' to the team by contributing, blending and honing ideas together. In addition, learning and innovation are essential activities in healthcare, as clinicians are often still training or new to the unit, and practice is constantly evolving. This means people need to ask questions, raise difficulties, report mistakes, double check each other's work and design new ways of doing things, to optimise learning and patient safety.

The central role of psychological safety in promoting collaboration

Yet all of this is 'tiger country', fraught with the risk of blowback and conflict. All of us, at some point, have felt uncertain about what to do but not wanted to expose our ignorance; felt concerned that someone else might be making a mistake but not wanted to offend them; or felt hesitant to suggest an embryonic idea in case it seemed stupid when considered in more detail. Anytime we voice our thoughts, there is the possibility that we may be disparaged, rebuked, or offend someone else. Hierarchy exacerbates this risk. So, whenever we consider participating, we analyse the risk-to-benefit ratio. If the risk is perceived as high, we stay quiet. This is the tension between individual reputation and team performance. Yet when there is psychological safety, people will risk their reputation for the sake of the team and a shared objective.

Psychological safety can be defined as 'a person's belief that the environment is safe for interpersonal risk taking';[1] in other words, I feel confident the team will continue to accept, value, and assist me, as I learn and collaborate imperfectly. When Amy Edmondson started investigating the influence of psychological safety on teamwork, one of her first studies analysed the link between psychological safety and drug errors in hospitals.[4] She was surprised to find, in contrast to her initial hypothesis, that higher psychological safety was associated with higher rates of drug error reports. Further analysis revealed that psychological safety enabled greater discovery and reporting of drug errors. In teams with high psychological safety, people routinely reported their own mistakes so strategies could be developed to prevent others repeating it, and double checked each other's work to optimise patient safety across the team. The leaders typically had high standards, coached their team, were invested in their team member's success, acted to level out the hierarchy, and were not offended by well-intentioned questions or problems.

The central role of psychological safety in enhancing quality

Often people fear that high psychological safety may permit sloppy standards but, in contrast, the evidence suggests that peak team performance is not possible without it. Edmondson directly addresses this in her recent book, 'the fearless organisation'.[5] She regards the level of 'psychological safety' and 'quality' in an environment as two separate, yet interacting, parameters. She describes that when leaders foster high psychological safety with their people, it is like 'releasing the breaks' on team interactions required to optimise performance. High psychological safety promotes motivation, learning and collaboration, which then enables people to achieve high standards. A cooperative group routinely outperforms an exceptionally clever individual, as combining the power of diverse perspectives enables plans to be refined, challenges overcome, and problems fixed early.[3,6] To realise the potential value each person can bring – their knowledge, insights, background, questions, concerns, and creativity – requires

Table 1. Practical ways for leaders to foster psychological safety within their teams.

Qualities	Promoters: Actions that foster psychological safety	Inhibitors: Actions that hinder psychological safety
Respect	Courteous. Take turns to speak for similar periods. Declare your plans will be improved by other's input. Actively seek contributions from others and explore their perspective. Listen attentively.	Rude, shouting, insulting. Interrupt or talk over other people. Make remarks that disparage or embarrass others.
Humility	Treat others as equal. Appreciate other's contributions. Acknowledge juniors are just earlier on the same journey as you. Declare that you are still learning. Admit your own limitations and fallibility. Acknowledge the impact of external factors on performance. Respond productively and find out more when someone raises concerns or highlights flaws in your ideas or plans.	Put yourself first. Amplify hierarchy. Assign success solely to yourself. Never reveal your uncertainties or errors. Respond aggressively and shut down discussion when concerns or problems are raised.
Acceptance	Inclusive Celebrate and incorporate other's differences. Set appropriate expectations. Communicate understanding that mistakes are inevitable during learning and appreciate the detrimental impact of external factors on performance, eg. high workload or night shifts (and design plans accordingly to optimise safety, eg. effective supervision).	Endorse cliques. Promote your own views or preferences. Demand perfection and not take account of external factors.
Interest	Use a person's name. Show interest in the evening shift or weekend off. Have coffee with the team. Find out about people, eg. family, hobbies or career goals	Not ask/use a person's name. Make no effort to pronounce a person's name correctly. Take no interest in a person as an individual.
Appreciation	Buy coffee for the team. Publicly thanks others for their contributions.	Take credit for another's contributions. Lay blame unfairly.
Care & Assistance	Ask about challenges. Show kindness and compassion. Share information or resources. Coach. Make arrangements for career promotions for team members. Design systems that work well for the team.	Not ask about or disregard problems. Offer no help or flexibility.

an atmosphere that encourages them to engage with each together to achieve a common goal. Alternatively, if the psychological safety level is low, people will focus on risk management and self-preservation, and stay quiet.[7] Another key concept for optimising performance that dovetails with psychological safety is a 'growth mindset'. This approach focuses on continually developing skills, accepts that mistakes are an inevitable feature of extending skills and sees them as learning opportunities.[10,11]

Within healthcare, simulation-based research studies have highlighted the powerful impact on team performance from seemingly minor violations of psychological safety. One RCT involved an immersive scenario with NICU teams managing a deteriorating newborn, when when an international expert made mild and general disparaging remarks about the healthcare system at the start, this resulted in substantially worse team performance and poorer clinical outcomes.[8] Jenny Rudolph, at Harvard's Center for Medical Simulation, proposed the concept of creating a 'safe container' for learning.[9] Learning and performing complex tasks occur at the distal edge of a person's skill level, where mistakes or crevices in knowledge are most common. This makes it a high-risk zone for health professionals needing to protect their reputation.

The central role of leaders in fostering psychological safety

Senior clinicians are responsible for setting the standards and creating a framework that encourages a growth mindset and psychological safety. A psychologically safe environment is characterised by qualities such as respect, humility, acceptance, interest, appreciation, care and assistance, which all contribute to creating interpersonal trust. Table 1 suggest some practical ways these qualities could be enacted, based on the literature and our own research on feedback interactions.[12,13] However, this is not a 'magic recipe' that can be thoughtlessly enacted, as the potency lies within the authentic beneficial intent driving each behaviour.

It is increasingly clear that psychological safety plays a central role in high performing teams. I hope the ideas outlined in this article may stimulate your thinking on how to foster it within your healthcare teams.

Full Reference list available online

Medical conferences in the COVID-19 era

Prof
MPH, MD, PhD, FRANZCOG, FRCOG, FACOG

One of the highlights of the triennial FIGO World Congress in Vancouver back in 2015 was voting for the city to host the 2021 Congress. The RANZCOG bid had taken shape years before and all of us present at the meeting were overwhelmed with excitement, and trepidation. The College bid was ultimately successful and Sydney was set to host what promised to be one of the great women's health meetings of the world.

It turned out that the bidding process that won us the privilege to hold FIGO 2021 in Sydney was just the beginning. It is difficult to describe the amount of work that went into preparing for the meeting. Running a meeting for an anticipated 8000 delegates from almost every country in the world is no easy task. College staff and an army of volunteers expended an enormous amount of time and energy shaping what had the potential to be a flagship meeting for our speciality. All seemed to be going well until the beginning of 2020 and the first wave of COVID-19 infections in Australia.

The emergence of COVID-19 has had a profound effect on medical and other scientific conferences. Analyses have reported that by the second half of 2020, almost half of all conferences had been cancelled and 75% of the remainder were postponed.[1] When conferences did eventually run, about 70% were in a fully virtual format, with the majority shortened. The flagship journal *Nature* first addressed the effects of the pandemic in March of 2020:

> As the coronavirus pandemic marches around the world, leading to unprecedented measures to stop the virus's spread, the number of scientific conferences being cancelled is rising and researchers are scrambling to find alternative ways to share their work and interact with collaborators. Some of these discussions are even pushing researchers to rethink the concept of meetings entirely: what is the point of a conference now?[2]

A year later, *Nature* was sizing up the future after a year of disruption to scientific meetings:

> Although researchers are getting 'Zoom fatigue' just like everyone else, they've learnt to appreciate virtual science conferences during the COVID-19 pandemic, according to a poll of more than 900 *Nature* readers. After navigating a year of online research presentations, the majority of survey respondents (74%) think that scientific meetings should continue to be virtual, or have a virtual component, after the pandemic ends. Readers cite the ease of attending from anywhere in the world as a major perk, although they admit that virtual events haven't been able to simulate the networking with colleagues they enjoyed in person.[3]

Medical conferences have a broad social impact. Not only do they foster research and education, but other key outcomes include policy development, career and personal skill development, as well as marketing of new technologies and equipment. Of course, interactions with colleagues at the meeting itself and associated social events are important. It is also worth remembering that 'in addition, national meetings act as major drivers of regional economies for a host city because the meeting 'community' encompasses meeting planners, attendees, convention centres, hotels, restaurants, transportation, and more.'[4]

Medical conferences evolved before the current era of global connectivity, in a time when it was necessary to travel to present ideas to, and connect with, your peers. It is now clear that there are also well-recognised negatives of in-person conferences and meetings. It has been estimated that a typical four-day conference with 1000 attendees generates about 3000 tonnes of CO_2 emissions.[5]

As a recent blog post from the *BMJ* put it:

> While international medical conferences represent a major industry, they come with an excessive carbon footprint. Conference organisers therefore have a duty to make them both more sustainable and ecologically responsible. The impact of conference travel is little appreciated or researched, but one study has shown that attending a 2.5 day conference increases an individual's carbon footprint by more than 6.7 times the normal EU daily level of production.[6]

Despite commendable optimism about the direction of the pandemic, it became clear that it would not be possible to hold an in-person FIGO congress in Sydney, and the difficult decision was made to change to a virtual meeting format. Having been involved in the successful campaign to bring the world congress to Australian shores for almost a decade, and having devoted hundreds and hundreds of hours to preparations, I found this a heartbreaking decision. It was, however, the correct decision: at the time FIGO was scheduled to run, Sydney was battling a prolonged and devastating outbreak of the COVID delta variant. An in-person

conference would have been a disaster. Converting to a virtual format allowed the organising team – both in Australia and the international FIGO committees – to deliver a great online meeting with enormous global reach.

It is now clear that virtual and hybrid meetings are the future. The pandemic crisis has given us pause to reimagine what a conference is and what such meetings can deliver for their participants. The technology at our disposal to deliver a virtual meeting has advanced rapidly and allows a real-time, high-quality experience for those present. Virtual events reduce travel and allow participants who might not be able to attend an in-person event – either because of cost, geography, or both – to be present and engaged. Interactive chat and Q&A tools foster interaction: indeed, people who might feel inhibited about asking questions at a live microphone in a lecture hall often have no issues with posting their questions or comments online. Sessions can be recorded and watched at leisure, or repeatedly, as desired.

There also are a number of important negative aspects to virtual meetings. Everyone has experienced 'Zoom fatigue' and it is difficult to spend lengthy periods in front of a personal computer. Similarly, when participants are joining from their home, hospital or office, they commonly multitask and complete other work or home tasks at the same time, drawing their attention away from the meeting. Many conferences feature workshops and practical sessions that are well attended. These are difficult to provide in a virtual setting; however, there is now enormous incentive for development of virtual reality simulation systems that can be delivered allowing for remote teaching and even assessment. These virtual reality practical sessions are likely to become *de rigueur* for medical and scientific meetings in the very near future.

There is no way that conferences that exist in a purely online environment can replicate the experience of in-person meetings, with the opportunities they provide to strengthen personal relationships and networks. For this reason, and despite the environmental advantages of conferences existing in a virtual setting, hybrid meetings – with a combination of a physical meeting with strong virtual component – are likely to become the accepted standard in the very near future. Key speakers who are unable to travel can speak and take questions remotely. Issues of affordability, equity, and accessibility for potential participants are neatly dealt with. This democratisation of learning will overcome physical and other borders, aiding the dissemination of knowledge.

The pandemic has had a transformational effect on medical education across the globe. All aspects of education – from medical schools to vocational training, and ongoing professional development for clinicians – have been profoundly affected.[7] One of the major sources of professional development in our profession traditionally has been conferences and it is easy to be sentimental about them. Yet the crisis of the pandemic, the economic resources available for education and training after the devastation of COVID-19, and the stark realities of climate change will make the decision for us. Hybrid and virtual meetings are the way forward, and we must embrace them.

The FIGO meeting ultimately was a resounding success, attracting thousands of participants from around the world and an outstanding scientific program. Obviously, it was deeply disappointing not to be able to meet in person, but scientific alliances were forged, new friendships made, and strong collaborations developed to further women's health globally. What more could we have asked for?

References

1. Ha E, Yong J, Lim S, et al. The impact of SARS-CoV-2 (COVID-19) pandemic on international dermatology conferences in 2020. *Front Med Dermatol*. 2021;8.
2. Viglione G. A year without conferences? How the coronavirus pandemic could change research. Nature (news), 20 March 2020.
3. Remmel A. Scientists want virtual meetings to stay after the COVID pandemic. Nature (news), 2 March 2021.
4. Evens RG. The impact of a pandemic on professional meetings. *Radiol Imaging Cancer*. 2020;2(3):e204012. doi:10.1148/rycan.2020204012
5. Bousema T, Selvaraj P, Djimde A, et al. Reducing the carbon footprint of academic conferences. *Am J Trop Med Hyg*. 2020;103:1758-61.
6. Delacrétaz E, Delacrétaz R, Nicholas Rowe N. Sustainable medical conferences in the post-COVID-19 world. BMJ Blog, 27 August 2020.
7. Robson S, Grabau B. How will doctors learn after the COVID-19 pandemic? MJA Insight. 31 August 2020.

‘Dr Google’: using the internet for good

Dr Rebecca A Szabo
MClinEd (hons), MBBS (hons), FRANZCOG
O&G, Medical Educator, Senior Lecturer
Royal Women’s Hospital
University of Melbourne

As a clinician, medical educator and avid user of social media and online resources, I have previously published a piece called *Hippocrates would be on Twitter*[1] and so was asked to write this piece article. My opinion, supported by growing evidence, is that Dr Google is used by almost all our patients, students and peers in some way, often enhancing doctor-patient interactions. Thus, it is not about overcoming Dr Google but accepting it exists and indeed harnessing it for good. I’d also argue it is about thinking ahead to what might come after Dr Google, such as applications of artificial intelligence, so the medical and healthcare professions can have a greater influence from inception.

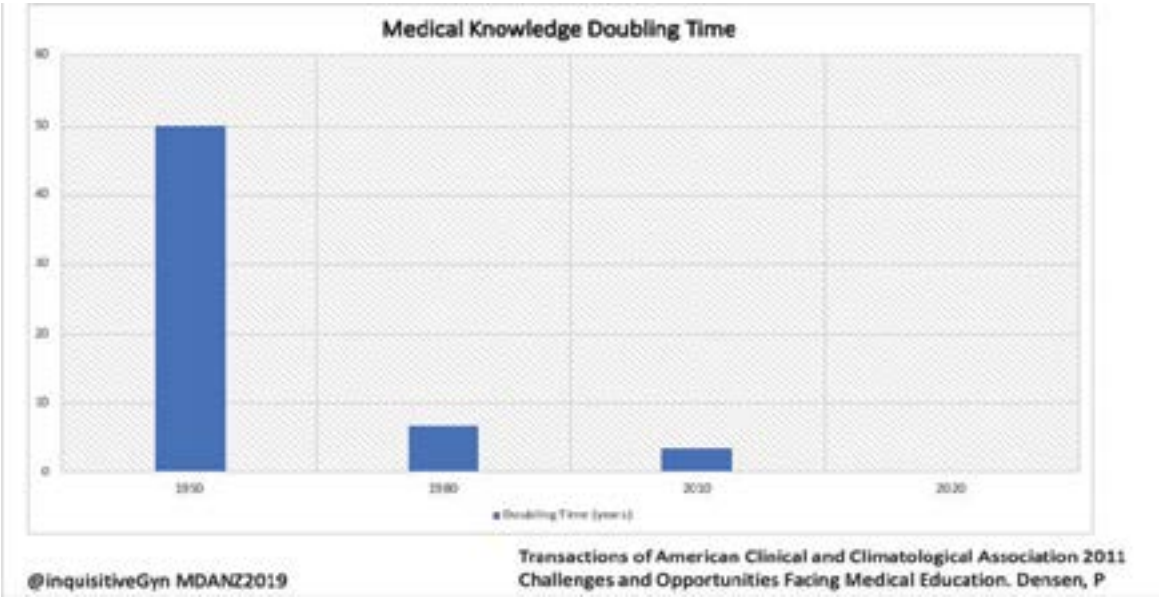
It is standard to be taught best practice with regards to traditional science communication at medical school, including critical appraisal of scientific literature. I think we’d all agree this is a vital and lifelong skill we need as clinicians, scientists and educators to provide the best evidenced-based care for our patients, forward scientific knowledge in our field of women’s health and educate future generations of those providing O&G care.

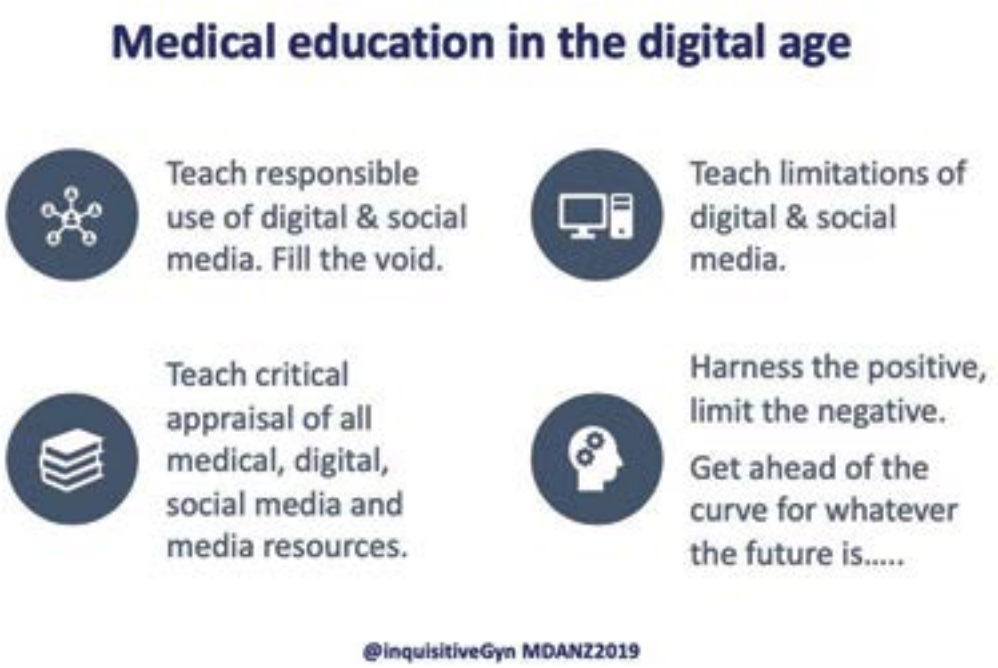
As with traditional information sources, like scientific papers, we have a responsibility to 1. understand how and why online medical searches are done, 2. educate our trainees, students and patients on how to identify online information and misinformation and 3. Use Dr Google with our patients, trainees and students in a responsible way and ideally 4. co-design and review information with patients, trainees and peers. Hopefully this article provides some evidence, food for thought and practical tips.

Democratisation of information

The world wide web, or internet, came into being not that long ago, in the 1990s, forever changing accessibility to information and each other. This was information that was previously only held in encyclopedias, libraries or by experts like us. As access to the internet has become more prevalent, so too has access to information – making it accessible virtually instantaneously – to almost anyone, anywhere. The impact on access to health information for those living in rural, regional and remote Australia cannot be underestimated.

In 1996, just 1.6% of Australians had access to the internet at home; by 2015, this had increased to 86%.[2] As of 2022, nearly all Australian adults (99%) have access to the internet. 91% of Australian adults have a home internet connection, and three-quarters of these have an NBN connection.3 This is in addition to the many smart phone and tablet devices used to download data. In the first half of 2021, almost all (98%) older Australians aged 55+ used the internet, up from 76% in 2019, prior to COVID-19 lockdowns.[3]





Dr Google

Google, was founded in 1998, a year before I graduated from medical school. The use of 'Dr Google' and the internet for health information wasn't included in my medical school curriculum. At the time, as in previous generations, it was conceivable that doctors could learn and know everything and be the one source of truth for our patients.

In 1950, medical knowledge had an estimated doubling time of 50 years. In 2000, when I was an intern, that figure was closer to 10 years.There has been an ongoing exponential increase in knowledge, and prior to COVID-19 the projected doubling time in 2020 was just 73 days.[4] That figure has almost definitely shortened with the avalanche of information we have all experienced since the pandemic began, with WHO calling it an 'infodemic'.[5] This has made it impossible to learn and know everything without a Google or other search!

Much has been said about 'Dr Google' in the medical and health literature in the past twenty or so years. Doctors tend to respond to online searches by their patients in one of three ways: 1. by reacting defensively and asserting their expert opinion; 2. by collaborating with the patient to analyse the information ; and 3. by guiding the patient to reliable health information websites.[6,7]

Whilst there is valid concern of the veracity of information patients may find, there is a growing body of evidence that patients seeking online information improve their knowledge and self-advocacy.[8] Of note, women are more likely than men to seek health information online.[9] Evidence has shown that more patients are searching the internet prior to consultations for answers to symptoms and to prepare for a consultation.[6,8,10] Reassuringly, several Australian and international studies have demonstrated that internet searches do not undermine the doctor-patient relationship, and well-informed patients contribute positively to interactions.[6]

The Australian Women and Digital Health Project is one of the most recent studies conducted in Australian women, published in 2018. The study demonstrated that women are highly engaged with online health information regardless of their age or education level.10 The Australian Women and Digital Health Project found that 'participants were engaging actively, creatively and critically with online information, using it in a number of different ways to complement rather than supplement medical advice'.[10]

With regards to the 'defensive reaction' there are memes and mugs stating 'don't confuse your Google search with my medical degree' yet most – dare I say all – doctors have used Google to search for information. We need to be able to set aside our own ego and bias and work with patients to ensure they have best knowledge and the tools to critically analyse them. There is a more recent meme equating to 'don't confuse your one-hour lecture with my lived experience'. Whilst specialist training is well beyond a one-hour lecture, I hope the point is clear. For best patient care, we need to work together with our expertise and the patient's lived experience.

Scepticism about Dr Google is understandable given concerns about lack of regulation of information on the internet and lack of context for how a patient has consumed that information. Whilst internet searching can lead to conflict if the patient values internet-derived information above that of the doctor, causing them to ignore their advice[6,7] evidence shows this occurs rarely. Evidence from those searching before attending ED or a GP consultation has shown a positive impact on the doctor-patient relationship, particularly for those with greater e-health literacy, and was unlikely to cause patients to doubt the diagnosis by a practitioner or to affect adherence to treatment.[6,8,11]

Healthy scepticism should always exist, including of traditional scientific information, but defensive reactions can harm a patient-doctor interaction. We can, and must, move past this and work with patients to view and analyse this information together – by directly asking our patients what they already know, where they have learned this information and trusting they understand that not everything on the internet

is fact or complete. Evidence and common sense dictates that most people do know this.

Health literacy can be defined as 'the ability of an individual to obtain and translate knowledge and information to maintain and improve health in a way that is appropriate to individual and system contexts'.[12] Digital literacy is described as 'the ability to identify and use technology confidently, creatively and critically to meet the demands and challenges of living, learning and working in a digital society'.[13] Digital and health literacy are key factors in understanding information and how to use it, as well as reducing the spread of misinformation.[14]

Misinformation

Along with 'Dr Google', terms like misinformation and disinformation have become widely used and understood. Misinformation is incorrect or misleading information presented as fact, either intentionally or unintentionally. Disinformation is more sinister and is a subset of misinformation, that which is deliberately deceptive.[15] It's the misinformation and disinformation that probably most result in frustration and a defensive reaction. It's also essential we know if patients have encountered misinformation and disinformation to correct and counter it. Equally, misinformation and disinformation are not new. They have existed for centuries in the form of word of mouth, family advice and from mainstream media. Online sources and Dr Google have merely amplified access and proliferation.

A solution – ask, have you searched online? What did you find?

An alternative to a defensive reaction is to teach ourselves and our patients how to critically appraise online information and encourage critical thinking with regards to all information sources, whether online, from friends and family or from scientific literature. Embracing this stance can improve health and digital literacy for us all – which can only be a good thing. I would encourage us all to acknowledge Dr Google with patients and discuss their online searches with them as well as direct them to information.

Democratisation, diversity and inclusion

Using 'Dr Google' with patients democratises information and assists us including all patients. By embracing 'Dr Google', we can harness it for good by using its many features including Google Translate. Sites for cultural, demographic and language groups, including First Nations, LGBTQI+ groups, as well as information from other countries can all be accessed. Thus, Google can improve access to information created for and by those from culturally and linguistically diverse backgrounds. Whilst Google Translate is imperfect and does not have all languages, it is another accessible online tool that can be used and hopefully will improve in future. In this way we can ensure information is inclusive for our patients' many diverse needs and truly equitable.

Our obligation as educators/clinicians

Despite this explosion in knowledge and increased use and accessibility of the internet, creation and use of online medical and health information, how to combat misinformation and disinformation is still not routinely taught in medical schools or training curricula. Given the evidence suggests we do not need to overcome 'Dr Google', but instead harness it for good, we need to know how to access and identify the best information and effectively

counteract misinformation and disinformation with our students, trainees and patients.

As mentioned, few existing healthcare curricula or courses focus on online information and curation. There are programs in media training for science and health professionals and these often include online science communication and social media. Given misinformation is most proliferated on social media, the few existing courses and frameworks for critical appraisal of online information often apply across both these areas as if in a Venn diagram.

UNESCO Handbook for Journalism Education and Training

One standout existing free resource on information and disinformation is *The Handbook for Journalism Education and Training* created by UNESCO.[15] Whilst it is specific to journalism, not healthcare, it is an excellent resource and arguably provides an excellent framework.

The curriculum, which has a pedagogical heuristic approach that encourages lived experience or case examples, could easily be adapted for healthcare and our specific context. The modules cover topics including information, disinformation, fact checking 101, digital technology and social media verification.[15]

CRABS framework

A framework to equip the public to spot red flags in health information online using the mnemonic CRABS14 has been developed by Australian critical care nurse and academic, Dr Jessica Stokes-Parish. The framework aims to leverage evidence-based educational strategies for empowering the public to determine truth from fiction.

C – Conflict of interest
R - References
A - Author
B – Buzz words
S – Scope of practice

The framework is intended to be applied as an initial guide and does not replace a full critical appraisal.[14]

Conclusion

Humans have not and cannot change our cognitive ability to learn more. We therefore need to maximise our ability to curate and access knowledge. Just as we use Google to obtain information, so do our patients, their families, our trainees and students. Yes, that means there is access to both information and misinformation. As with other skills taught during medical school and specialist training to critically appraise scientific and medical literature, we need to learn how to address misinformation and disinformation online for ourselves and with our patients. We need to learn how to harness the internet for good, and conduct research to understand its role in women's health. We also need to embrace and teach e-health literacy, critical thinking and finally co-design information and training of these skills with our patients and each other.

References

1. Szabo RA. Hippocrates would be on Twitter. *MJA*. 2020;213(11):506-7. e1.
2. Hill MG, Sim M, Mills B. The quality of diagnosis and triage advice provided by free online symptom checkers and apps in Australia. *MJA*. 2020;212(11):514-9.
3. Authority A-ACaM. Communications and media in Australia: How we use the internet. 2021.
4. Densen P. Challenges and opportunities facing medical education. *Transactions of the American Clinical and Climatological Association.* 2011;122:48.
5. Zarocostas J. How to fight an infodemic. *Lancet*. 2020;395(10225):676.
6. Cocco AM, Zordan R, Taylor DM, et al. Dr Google in the ED: searching for online health information by adult emergency department patients. *MJA*. 2018;209(8):342-7.
7. Tan SS-L, Goonawardene N. Internet health information seeking and the patient-physician relationship: a systematic review. *Journal of Medical Internet Research*. 2017;19(1):e5729.
8. Van Riel N, Auwerx K, Debbaut P, et al. The effect of Dr Google on doctor–patient encounters in primary care: a quantitative, observational, cross-sectional study. *BJGP open*. 2017;1(2).
9. Baazeem M, Abenhaim H. Google and women's health-related issues: what does the search engine data reveal? *Online Journal of Public Health Informatics*. 2014;6(2).
10. Maslen S, Lupton D. "You can explore it more online": a qualitative study on Australian women's use of online health and medical information. B*MC Health Services Research*. 2018;18(1):1-10.
11. Wald HS, Dube CE, Anthony DC. Untangling the Web—The impact of Internet use on health care and the physician–patient relationship. *Patient Education and Counseling*. 2007;68(3):218-24.
12. Liu C, Wang D, Liu C, et al. What is the meaning of health literacy? A systematic review and qualitative synthesis. *Family Medicine and Community Health*. 2020;8(2).
13. Coldwell-Neilson J. Unlocking the code to digital literacy: Department of Education, Skills and Employment; 2020.
14. Navigating Credibility of Online Information during COVID-19: Using mnemonics to equip the public to spot red flags in health information online. JMIR Preprints. 2022.
15. Ireton C, Posetti J. Journalism, fake news & disinformation: handbook for journalism education and training: Unesco Publishing; 2018.

Guided curiosity: how to filter the torrent of info

Dr Casey Parker
MBBS, DCH, FRACGP (Grad.Dip. Anaesth), DDU
District Medical Officer,
Broome Hospital

'Heaven is satisfied curiosity.' ~ Paola Antonelli

I work as a rural generalist in the beautiful Kimberley region of Western Australia. I am a GP by training and have postgraduate qualifications in paediatrics, anaesthesia, and diagnostic ultrasound. Occasionally, I trifle in obstetrics when the need arises! Most of my time is spent in the emergency department and the operating theatres treating 'whomever rolls in the door'. In our practice, we can never say no.

Rural generalists are the platypi of the medical world – strange creatures that seem to be composed from spare parts of all the other specialties. The old saying states that we are 'Jacks of all trades, master of none.' However, here I dissent from the traditional wisdom.

Our patients deserve the same quality care that they might receive in any metropolitan hospital. We need to be masters of our broad trade. Invariably rural hospitals are not as well-resourced as our city cousins. Frequently we do not have the same equipment or medications, often not able to provide specific services. These are the realities of rural practice; however, I believe that it should never be the knowledge of a rural doctor that results in lesser quality care.

This is why lifelong learning is critical for anybody working outside of the larger academic centres. So how does one stay 'up to date' in a dozen disciplines once you are out there in the real world of practice? There is a staggering volume of education and medical evidence being piped into our phones, emails and lunchroom cork boards every day. This has been described as 'drinking from a firehose'. How can adult learners identify the educational gold and avoid the time sinks in this torrent of information?

For many years I found it easy to settle for 'good enough' practice. I stuck with what I knew, what I had been taught and what seemed safe. The trouble with this attitude is that one inevitably lands upon the floor of adequacy and never reaches the ceiling of excellence. For me the key to aiming at that ceiling where our patients get the care that they deserve is curiosity.

Recent neuroscientific research[1] has shown that curiosity is an intrinsic drive within the human brain. Our brains are hard-wired to seek new information. Our mesolimbic system delivers a similar dopaminergic reward when we satisfy our curiosity that we might receive when we eat our favourite treat, match on Tinder or win on a big bet.

Curiosity is at the core of learning. Gruber et al[2] showed that learners in a state of increased curiosity are more likely to retain information. In fact, the absence of curiosity probably impairs the learning of new ideas. There is a close relationship between the curiosity-reward system and the hippocampal memory structures within the human brain. In order to optimise learning opportunities in day-to-day practice, I try to maintain a constant posture of curiosity.

However, there is a catch. Whilst curiosity is unarguably a desirable attribute for any lifelong learner, our attention can only be directed at one idea at any point in time. Our time is finite, our sensory filters are not particularly discriminating. So how can we ensure that the new ideas we put into our curious brains are going to be useful in our practice? We need filters.

The answer to that dilemma for me was social media. This may seem paradoxical. Twitter is the world's most aggressive, often hate-fuelled media stream; but only if you do not curate it carefully.

Around 2010, a group of mainly emergency medicine doctors started a social media movement known as #FOAMed (free, open-access medical education). Within a few years this concept had blossomed from a handful of ED docs sharing ideas across the globe into a community of the world's leading specialists, educators and knowledge translators in many different specialties. There is even a subcategory hashtag known as #FOAMOG for those interested in staying up to date, and part of the conversation, in O&G. Social media has become a necessary tool for the dissemination of medical education and evidence.

The FOAMed movement has diversified from a handful of blogs into a serious academic platform featuring podcasts, conferences, online courses and even some fellowships. No longer confined to Twitter, there are many platforms out there that carry this content. Best of all, it remains entirely free and democratic. The FOAMed movement has delivered high-quality medical education to the developing world, spread to non-English-speaking lands and areas such as rural and remote Australia where it was previously difficult to access the cutting edge of our science and practice.

So how can one use social media to resolve the dilemma of information overload and our need to stay afloat and up to date?

Start by following a few high-quality medical educational FOAMed projects within your area of interest. For example, in O&G you can follow sites such as The OBG Project (obgproject.com), Obs & Gynae Critical Care (obsgynaecritcare.org) , Bits 'n Bumps (bitsandbumps.org). All of the major journals also provide feeds through their websites – look for the RSS feed button on their home pages. There is a list of suggested sites below.

In order to save yourself time, you can create an RSS (really simple syndication) feed and have any new material from these projects or specific journals delivered directly to your inbox. Examples of free RSS feed aggregators include: Feedly, Inoreader or Newblur. These are basically portals through which you can subscribe to content from trusted sources and save yourself the time of scouring the hot mess of the internet for useful content. You can even subscribe to already created content feeds though services such as Reddit.

Next you can use social media to follow trusted individuals or organisations. Start with a few and spend some time scrolling through their news feeds. You will identify other individuals who share useful information and links. Enlist your colleagues through your local WhatsApp network to join and share content, thoughts and questions. The hallway chat has gone electronic! This is how the hivemind of the FOAMed community functions – we act as aggregators and filters for one another. This socialised learning can actually be fun; the good stuff gets shared, the nonsense is lost. You can ask questions and get curated resources within the space of a few tweets.

This is a brave new world. The advent of social media has changed the way we communicate and learn. I believe that the internet is a tool; one that if used wisely can allow us to maintain our curiosity, our knowledge and provide our patients in the bush with the best medical care possible.

Recommended Online Educational Sources

- Perspectives Podcast from the Green Journal of Obstetrics and Gynaecology https://journals.lww.com/greenjournal/Pages/podcasts.aspx
- PROMPT Maternity Foundation YouTube series www.promptmaternity.org/Listing/Category/prompt-video-content
- The Ob / Gyn Podcast www.obgyn.fm
- Conversations in Obstetrics and Gynaecology cog.podbean.com

References

1. Gottlieb J, Lopes M, Oudeyer P-Y. Motivated Cognition: Neural and Computational Mechanisms of Curiosity, Attention and Intrinsic Motivation. *Recent Developments in Neuroscience Research on Human Motivation*. Available from: https://hal.inria.fr/hal-01404468/document.
2. Gruber M, Raganath C. How Curiosity Enhances Hippocampus-Dependent Memory: The Prediction, Appraisal, Curiosity, and Exploration (PACE) Framework. *Trends in Cognitive Sciences*. 2019;23(12):1014-25.

Consumer Network

Consumer perspective of lifelong learning

Keshala De Silva
Consumer Network Woking Group member

Lifelong learning in medicine is often focused on updating skills and knowledge. The changing needs of the population and the commitment of medicine to empower general population must also be considered as part of lifelong learning. In O&G, the lived experience of women and their families offers insights that can improve the quality of medical research, training, policy and health outcomes.

My awareness of women's health began with the birth of my first child. I was in my mid-twenties when I gave birth for the first time. After I had given myself time to heal and started to push myself back to normal routines of life, I didn't understand why it felt like everything inside me was about to fall out when I exercised and why certain parts of my body hurt on a daily basis. Three years later, I found out that this birth had left a permanent mark on my pelvic floor; I was diagnosed with bilateral levator avulsion and prolapse. This diagnosis knocked me for six. I had no idea that this kind of injury can impact your daily movements and breathing. So, with an infant and a three-year-old, I had to learn how to breathe properly again and how to properly function with a torn pelvic floor. At the time, I was told that there was no treatment available unless I was incontinent. That was when I decided I deserved better and committed to educating myself. Little did I know this process would become lifelong. There are so many stages in our lives: menstruation, fertility, menopause and post-menopause. It was daunting to learn how little I knew about my own anatomy and how these stages of my body would impact me and how I would manage these changes. In the process of educating myself, I would find many women who were also looking for answers about their health and that was one of the reasons that pushed me to apply for consumer representative roles in women's health.

My mother migrated to Australia from Sri Lanka with a 4-year-old and a 6-month-old, limited English and very little financial means. She suffers from incontinence and she keeps quiet on this. Like women in many different cultures, she was taught very little about her health and did not have easy access to resources to enable her to educate herself or even know what wasn't normal. I often wonder if she had the support back then, how much easier her life may have been as a mum in a foreign country, without family support. I wonder how this impacted her wellbeing. I think about this a lot because I moved countries during pregnancy and again a few months after birth. I had the privilege of education, the ability to speak English and the financial means to be able to advocate and seek support. One of the hardest parts of my experience was feeling alone and helpless. Since learning more about women's health, accessing resources and online support groups, I have felt comforted knowing that I am not alone. Not all women would have this opportunity, including my mother. Furthermore, many of the experiences of these women will not be known to those in the O&G community, as the impacts often occur outside of a clinical setting and may be such that the women involved do not feel they can seek further help and support.

As a part of my upbringing in my culture, I still carry an element of not wanting to appear helpless, show hardship and often say 'yes' even if I don't understand why or want to. Rarely is there time for a health professional, as part of the medical history and consultation process, to evaluate responses to consider if there may be influences that impact a patient's ability to speak freely. I often think back on my experience when I had fainted shortly after giving birth. I had learnt that I had lost a lot of blood during labour. The medical team were attentive, they had noticed my vital signs were irregular. At one point, when they had to leave me in the room alone in a wheelchair and the nurse had asked me if I felt like fainting, I assured her that I felt fine and smiled back. I fainted within minutes of them leaving and nearly fell out of the wheelchair, luckily the nurse saw me and caught me in time. As a woman with dark skin, I don't appear 'flushed' and in a clinical setting find it hard to feel my own discomforts. The simple 'yes' can mean much more and recognising these communication differences and experiences of people can make a big difference to care. This simple mentorship or engagement with women and families outside of clinical settings is one way that O&Gs can incorporate the experiences of women and their families into lifelong learning.

The experiences of women and their families are a resource. The challenge for organisations is finding how to genuinely engage with communities and finding the time to really listen and reflect on how the organisation can make a difference. In the UK, frameworks have been developed to actively involve

consumers in research design, policy development and medical program reviews. The Royal College of Obstetricians and Gynaecologists (RCOG) in the UK have supported the creation of the Women's Voices Involvement Panel, a group of 700 women from across the country who lend their experiences to influence and shape RCOG's strategic direction. RCOG also employ 14 consumer members who sit on all the Boards across the college. This is an important initiative which showcases lifelong learning for organisations and how a member-based college has incorporated the lived experiences of women and families in O&G.

As a research project manager in women's health, I have seen a shift in project design to incorporate the learnings and feedback of women and their families with lived experience, to ensure the research outputs creates sustainable changes that are culturally appropriate. Genuine engagement and partnership with women and their families from diverse backgrounds in research is an important aspect of lifelong learning which will support equitable and sustainable changes. Based on my experience and that of women and community groups I have met, their experiences fly under the radar in terms of medical research as they are often not actively engaged in the process. The learnings, emotional load and time commitment from those that partner and collaborate in research is often required but not always heard or incorporated into the design due to a lack of time, budget or restrictions in research or funding requirements. I have been lucky to be able to witness clinicians and researchers in O&G who truly take the time to sit back and reflect on their practice but also continue to connect with women and their families, and Indigenous communities, after the research has ended.

Lifelong learning is a given of medicine, and these days it doesn't matter who you are, where you are from or what you do for work, the world is moving at such a pace we are all needing to learn and upskill. In medicine, the three aspects of lifelong learning have always focused on knowledge and skill. As a woman, I hope there will be a new component that includes how to engage with people with lived experience to improve services, research and policies.

Consumer Network

Knowledge ecosystems in women's health

Tessa Kowaliw
RANZCOG Council Consumer Representative
Consumer Network Woking Group member

Earlier this year, I discovered that I was pregnant at 40. After such a long time spent successfully managing my fertility, it was a great surprise. Having taken the best part of a decade off from paid work as a teacher to raise three children (who are now well on their way to becoming teenagers), falling pregnant now – right as I have reclaimed a small portion of my independence as a mother – was not on 'the road map' by any means.

Courtesy of the advocacy work I had previously undertaken regarding abortion decriminalisation and the diminishment of abortion care services in South Australia, I knew that I could ring the local pregnancy advisory centre to book an appointment without a referral. I was thankful for this option, though not entirely sure I wanted to proceed with it. As luck would have it, an acquaintance contacted me the same day to say she had also taken a pregnancy test that morning and discovered that she was also carrying an unplanned pregnancy. However, unlike me, she was unsure of where to go or to whom she should speak – her first port of call was to discreetly ask a friend for help.

What neither of us was prepared for was a waiting time of 3–4 weeks for a termination. Unfortunately, we South Australians are still awaiting the new health regulations which will allow providers to offer care that reflects new, decriminalised abortion legislation. As a result, once Omicron hit over Christmas, the requirement for women to attend a hospital setting for abortion care added further strain to a system that was already under pressure. During this agonising wait, I – like my acquaintance – found myself reaching out to easy-to-access care providers, such as local midwives and my GP, and a range of close friends. Whilst the medical professionals could talk me through what choices I could make, the information I sought from women was more about how I could make the choices I needed to make in coming weeks; having never experienced an unplanned pregnancy before, being able to call upon others who had 'been there, done that' before me was immeasurably valuable. From these trusted women, I heard stories of their own unplanned pregnancies, medical or surgical abortions, and blended families with 'surprise babies' and large age gaps between siblings.

In many cases, these women had not shared this information before, and whilst I was the beneficiary of them sharing their experiences, they also benefited in being able to tell their stories to someone in a similar situation. I learnt a number of things about what level of care to expect from the termination clinic, how having an extra child in a family of older children can 'work', and – most importantly – I was reminded of how much practical support I had around me, if I needed it. Ultimately, it was the sum of this information – which is highly personal and cannot be found in a brochure or set of guidelines – that helped me to decide that, crazy though it objectively was on every count, I would proceed with the pregnancy.

Unfortunately, at nine weeks, I instinctively knew something was wrong. A viability scan confirmed that I had had a missed miscarriage. Once again, I began researching online, speaking to friends, and consulting medical professionals to understand not only what to expect in the coming days, but also how to prepare for the experience physically, emotionally and spiritually. Much of the information of greatest value to me during this process again pertained to a far bigger picture of decision making than I could find in any single source.

In March, I conducted an online survey called 'Learning About Women's Health' to collect experiences from consumers of women's healthcare relating to the topic of 'lifelong learning'. I share this personal experience of mine because, based on survey results, it is a perfect example of how women learn and share information about their own health across their lifetimes. By starting the conversation and listening to lived experience, we can identify the key factors in how women learn, we can replicate some of this 'secret sauce' in women's health education, and the education of women's health providers and educators.

The survey received 30 responses from women (ie. consumers of women's healthcare identified as female by reproductive sex) living in Australia and New Zealand. These respondents were aged from 25 to 65+, with 70% between 25 and 44 years of age. When asked to describe how well they generally know their own bodies, 82% responded that they know their body either quite or very well. By contrast, when asked if medical professionals well understand the female body generally, 75% of respondents answered 'No'. Of interest here is how women come to learn about their female bodies to the positive extent indicated if their confidence in the knowledge held by medical professionals is so low.

Noting the age of the respondent cohort, the role of 'personal experience' emerged as integral to learning about their own bodies over time. In terms of the biggest influences upon a woman's current understanding of her body, these may include: 'studies, research and science' (76.2%), 'what other women have shared with me' (73.4%), 'my understanding of my family history' (69.6%), and 'what medical professionals have told me' (68.8%). However, the strongest influences upon this understanding are: 'how it feels' (92.6%), 'my experience of my body over time' (91.8%), and 'what I instinctively sense' (86.6%). As one respondent reflects: 'It's not until something happens that I've learnt [about it]. Not ideal in many circumstances!' Similarly, another respondent said she has learnt 'By living in it! Going through puberty, menarche, experiencing menstrual disorders and fertility delays, experiencing pregnancy, birth, breastfeeding, [and] weaning.' Whilst these answers relate to previous learning, when women want to learn more about their body – and 85.7% indicated they still do – they turn to personal research (95.2%), their GP (57.1%) or a friend (52.4%).

In both reflecting upon their current knowledge base and how they would continue to expand this, survey results reveal a theme of personal autonomy which underpins the consumer's knowledge of her own body. She is the agent of her own knowledge base, her experience of her body is her primary source, and she learns to source and integrate an ecosystem of information from multiple secondary sources, including medical professionals and peers. Indeed, this mirrors my own natural process regarding decision making around unplanned pregnancy and termination.

It is interesting to ponder whether the tendency towards 'learning by doing' or 'just in time' learning is indicative of a fundamental truth regarding women's health education (ie. that some things cannot be learnt or taught until they are experienced), or whether learning from experience is a natural consequence in a society that does not teach what women need to know. One respondent noted that 'there's a huge gap in women's education for the general population between high school and getting pregnant,' and of the education women have accessed via school programs, another respondent reflected that 'education as a young woman centred around not getting pregnant'. Both observations suggest that there is a knowledge gap for women's healthcare consumers that is not currently addressed by existing systems.

To further explore the details of this knowledge gap, one theme that emerged in answer to the question, 'What do you wish you had known about your body before now?' was 'hormones' (28.6%). This included women finding benefit in knowing, through experience, the role of hormonal cycles in overall health, and vice versa. Regarding the things women wish they had known about their bodies before now, 23.8% reported that they did not learn about this previously because it was not talked about, and 19% said it was not taught to them. This raises the question of whether working to reduce social stigma is as important as offering formal education in women's health. Nonetheless, respondents indicated that, if they were to be taught these things, the best person to have done so would have been their doctor or medical professional (57%), a mother/mother-like figure (47.6%), and peers (42.9%). The sense of a healthy ecosystem of 'education points' within personal, medical and social networks is evident in this picture. Indeed, only one third of respondents believe that the thing they wish they had known about their bodies before now could have been taught by 'no one – I needed to learn it myself'.

The greatest opportunity to proactively address this education gap for the cohort surveyed currently appears to be in relation to matters of perimenopause, menopause and post-menopause. Consumers indicated an overall lower confidence in their understanding of these topics as compared to those relating to earlier stages of the female reproductive lifecycle – 30% reported a low understanding of perimenopause; 26% provided neutral responses and 26% reported a low understanding of menopause; 37% reported a low understanding of post-menopause. Given the average age of respondents, this is consistent with the 'just in time' nature of women's learning and the likelihood that those surveyed are not yet in this phase of their reproductive lives.

Before pondering possible solutions to this knowledge gap, we must recognise there are two distinct issues that deserve further discussion. Firstly, women need to be better supported access the formative education they need to make better sense of the 'just in time' learning represented by the 'feelings', 'experiences' and 'instinctively sensed' information they derive from their own bodies, and the information they glean socially from peers. Secondly, medical professionals – from whom women believe they could have learnt what they needed to know, and to whom these women will turn when they want to learn more – need to be better positioned to potentially deliver this service to women as they build knowledge 'ecosystems'. The effective education of healthcare consumers is a worthy investment in preventative medicine and better outcomes.

It is my view, both as an advocate and educator, that both issues can be solved for the benefit of consumers and clinicians alike by emulating knowledge ecosystems and working in collaboration to deliver medical education. Whilst this is not a new idea (as an example, the *Royal College of Psychiatrists NHS guidance*[1] contains a literature review of the involvement of patients with lived experience in teaching and learning within Medicine), its uptake within women's healthcare in Australia and New Zealand by training and accreditation organisations, such as RANZCOG or the RACGP, would offer significant, multi-directional value. The direct sharing of patient stories makes education memorable and powerful, meaning that medical students are more likely to remember key messages.[2] Furthermore, if women's shared stories represent not only the culmination of lived experience but also the knowledge gained from speaking to other women, this opens a portal to more universal experiences with potential transferability in practice. With 70% of survey respondents indicating that they would be prepared to share lived experiences as part of medical or professional training for women's healthcare, there may be ready appetite within the consumer community to provide this kind of resource. Indeed, as my friends reported to me during my unplanned pregnancy 'reconnaissance', such sharing is mutually beneficial; whilst medical students may experience more powerful learning, the consumers who provide lived experience education also report benefits, such as feeling empowered, a raised sense of self-esteem and improved understanding about their own health.[3]

This said, we know that merely involving consumers as teachers of existing women's health curricula is not the whole answer in and of itself. Where collaborative medical education exists, there can be a tendency towards using the lived experiences of consumers to 'flesh out' existing academic or professional knowledge and theories, rather than to use patient experiences to expand knowledge and challenge orthodoxy.[3] Much like consumers, educational institutions run the risk of 'not knowing what they don't know' without consistent and direct conversation with the communities they ultimately serve; where clinical education is not cognisant of consumers' lived experiences, blind spots can form (which make consumers' perceptions of clinical knowledge worse). However, the 'business case' for pushing beyond this level of patient involvement in education can be extremely hard to make without significant support.

Given the high degree of experiential learning reported by consumers in the survey (who report that they know their bodies well or very well), perhaps there may be greater value in introducing the concept of 'consumer knowledge' with a view to teaching about it in its own right. This enquiry would not only add further dimension to medical perspectives of the female body, but its process could be an opportunity to co-design, co-deliver and co-assess new curriculum modules in women's health for the purpose of addressing the knowledge gap on both sides of the clinician-consumer fence. By teaching the clinicians both what consumers need to be taught and what consumers believe clinicians need to be taught (either conceptually or directly), clinicians will be better placed to impart relevant, useful knowledge when women 'don't know what they don't know', but could benefit from having access to this information ahead of time.

Whilst this may sound like a futile task of dubious value to some, and 'out of scope' to others, the Collaborative Pairs model – which was started by The King's Fund in the UK and has been subsequently used elsewhere (including Australia) – offers a framework for clinical and consumer 'pairs' to work together to design such pilot initiatives to improve outcomes.[4] In organisations that are already committed to providing the highest standards of healthcare via a culture of lifelong learning and have established consumer networks of trusted representatives, this process is even easier to initiate; the hard work of cold canvassing consumer communities and creating engagement funnels has already been done. Where the value of the consumer perspective is part of 'business as usual' in an organisation, inviting consumers to participate as partners in matters of education often becomes a natural evolution of the process of working together to improve outcomes. Just imagine the positive health outcomes for consumers that may flow from asking, 'What do you wish you had known?', if we commit to proactively providing the answer to tomorrow's clinicians and consumers through education.

References

1. Royal College of Psychiatrists. Learning from Experience: Working in Collaboration With People With Lived Experience To Deliver Psychiatric Education. 2021. Available from: www.rcpsych.ac.uk/docs/default-source/training/letb/pcitguidance-(002).pdf?sfvrsn=7465445a_4
2. Jha V, Quinton ND, Bekker HL, Roberts TE. Strategies and interventions for the involvement of real patients in medical education: a systematic review. *Medical Education.* 2009;43:10-20
3. Royal College of Psychiatrists. 2021. Online, p.6.
4. The King's Fund. Patients as parthers: Building collaborative relationships among professionals, patients, carers and communities. 2016. Available from: www.kingsfund.org.uk/publications/patients-partners

Q&A

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

Q What's the best way to choose and fit a pessary?

Dr Jerome Melon
FRANZCOG, CU
Urogynaecologist
Gold Coast University Hospital
and Queensland Pelvic Mesh Service

A Pessaries have a long-established history in the non-surgical management of pelvic organ prolapse and stress incontinence, with Hippocrates documenting the use of pomegranates soaked in vinegar as vaginal pessaries, as well as pieces of wood, cork, gold and silver. Pessaries are now made with non-toxic medical grade silicone that is latex free and does not absorb odours. They can be sterilised and used for years. Most women will be able to have a pessary fitted comfortably, with over 50% continuing use for a year or longer.

Choosing the right type

Pessaries work to reduce prolapse by elevating the pelvic organs out of the vaginal space. This may be achieved through two means: supportive pessaries held in place by levator muscle tone (ring pessaries with or without support, Shaatz, Gehrung, amongst others); and, space-occupying pessaries that instead fill the vaginal space (such as Gellhorn, cube and donut). Continence pessaries also include a thickened knob or rim that creates support under the urethra. Whilst the literature can be conflicting on the factors associated with pessary failure, most would agree causes include a wider genital hiatus, prior hysterectomy, a larger degree of prolapse, and lack of oestrogen use in post-menopausal women. Having said this, the vast majority of women can be successfully fit with either a ring or Gellhorn.

In my practice, all women are offered a pessary as part of their management options for prolapse. Generally speaking, I will generally offer all sexually active women a ring pessary (with or without support), simply because it is easy for the patient to self-manage. They are also an excellent interim measure for younger women with symptomatic prolapse who seek further children and therefore aren't ideal surgical candidates. At the initial or subsequent visit, I will instruct the patient on how to remove, wash, and replace the pessary on her own. This should be performed weekly, but may be done more frequently if desired. Most will remove the ring pessary for sexual intercourse, however some choose to retain it. Additionally, tampons may be used with a ring pessary in place. Should a ring pessary fail to be retained, I would usually then try a Shaatz.

In most cases, I will reserve Gellhorn or other space-occupying pessaries for women who are no longer sexually active, as these pessaries are harder for the women to self-manage. Given the shape of the Gellhorn and ability to create a suction effect, these pessaries appear to hold in place well. Despite this, some non-sexually active women will be better suited to a ring pessary as this is sometimes the better fit. If a sexually active woman is able to self-manage a Gellhorn or other space-occupying pessary, then there is no reason not to try. Should a Gellhorn fail to be retained, then I would usually try a cube next.

Finding the right size

Choosing the right sized pessary is a hard process to explain. It is not unusual for patients to try a few pessaries before finding the right fit. As a general rule, if it is slipping down too often or coming out easily with defaecation, then it is likely you will need to advise a larger size. The ideal size is when the pessary fills the vagina, but you are still able to run the examining finger between the pessary edge and the vaginal wall. Anteriorly the pessary should sit snug behind the pubic symphysis and if you push the pessary posteriorly, it should only move slightly. A pessary that is able to be flipped in the vaginal cavity is likely too small. Once in place, it should be comfortable for the patient.

To initially decide the size, I take a rough measurement of the distance from the pubic symphysis to the vaginal vault (D point) on stretch, using the examining digit. I then take a second measurement of the width of the mid vagina by spreading the index and middle fingers. This gives me an idea of which pessary size to try by comparing these mental measurements to the pessaries on the shelf. In my opinion, both measurements are useful as ,for example, some women may have a narrow vaginal width, despite a long vaginal length. In this situation, you must fit the pessary with the vaginal width as the limiting factor. Pessary sizing kits with sterilisable (often blue or yellow) pessaries are useful for those with less experience. Having said this, the majority of women most commonly fit a size 3, 4 or 5 ring pessary. Keep

in mind that when converting from a ring pessary to a space-occupying pessary, size for size may not fit given the additional bulk of space-occupying pessaries. A step down in size is often required.

The next important component of fitting the pessary involves asking the patient to strain and bear down, to see if the pessary will be easily expelled. If this is the case, then it may be too small or they may require a different type. Once the right fit is confirmed, I will then instruct women with a ring pessary on how to remove and replace it, so that they can continue to self-manage it at home. This is the ideal situation, with pessaries cleaned at each removal by simply rinsing under warm tap water. I will also ask the patient to pass urine before leaving the clinic to ensure voiding is uninterrupted. Vaginal oestrogen for postmenopausal women without contraindications is routinely prescribed.

Follow up

After the pessary fitting, I will typically organise an initial review appointment after a few weeks to see if any size adjustments need to be made. Once a patient is stable with their pessary, I will advise three-monthly reviews for those not self-managing their pessaries, or earlier if indicated. For those self-managing their pessaries regularly and without complication, this will be increased to six-monthly or yearly reviews. As always, patients should be counselled on the potential complications of pessary use and to return if any concerns arise.

Finally, tips for removing the stubborn pessary

Some pessaries are particularly stubborn and require additional tricks to remove them. This is most often encountered by Gellhorns due to the suction effect they can create on the vagina. To break the suction, one can sweep the examining digit medially between the base of the pessary and the vagina to break the seal. If this fails, one can try attaching a syringe to the drain on the shaft of the pessary and flushing it with 10ml of saline. Alternatively, the combination of a sponge-holding forcep to apply traction to the shaft whilst the examining digit tries to break the seal between the pessary and vagina is often successful.