O&G MAGAZINE

COMMUNITY

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a **RANZCOG** publication

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The College

Community

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

The College

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.

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From the President

Dr Benjamin Bopp
President

Welcome to the 2022 summer edition of *O&G Magazine* that focuses on 'Community'.

A community is loosely defined by Wikipedia as a social unit with commonality, such as place, norms, religion, values, customs, or identity. Our College has great diversity spanning many of these areas, with the commonality being our dedication to teaching and leading in women's health across Australia and Aotearoa New Zealand.

Topics explored in this edition cover various areas of College work, and showcase some of the individuals that best represent the dedication and achievements of the broad RANZCOG community.

December 5 is International Volunteer Day, and RANZCOG is a majority volunteer organisation.

Our paid College staff consists of approximately 120 employees across two countries; however, a large body of our invaluable College work is undertaken by the membership. All their work is pro bono, and around 450 members give their time freely to fill some 700 positions on over 70 College working groups, committees, Council, or Board. Still more members contribute as training supervisors, assessors, interviewers, question writers or examiners.

Recent months have seen the return of face-to-face assessments after the rapid and very successful pandemic pivot to online exams. Congratulations to the entire College assessment team for their flexibility and professionalism during these challenging times.

An online news story caught my eye, unfortunately I cannot remember where it appeared, but it commented that in 2010, one in three Australians volunteered in some capacity, which provided 700 million hours of input across sectors including sports, religion, education and social service.

The hours committed by volunteers have reduced by 250 million per annum, which is the equivalent of 6 million full-time jobs. Community still relies on volunteers, but the ability or wiliness to get involved appears to have declined considerably.

The importance of RANZCOG is not simply it's trans-nationality, but also it's scope across generations from prevocational to post-retirement members. It's a broad church with a diverse membership, and has always relied on people giving time to pass on knowledge, experience, and expertise.

Much recent and ground-breaking work has been done with our First Nations members around cultural competency, which will be detailed in an upcoming issue. Again this issue, we benefit from the opinion of our consumers and their network – it's important to note how others see us, what we do and how we could improve our service delivery.

Since the last *O&G Magazine* there's been significant College work including our highly successful Annual Scientific Meeting, held on the Gold Coast in October, with over 1000 face-to-face registrants and another 200 attending virtually. Thanks to the Organising Committee and College staff, particularly the events team, for a wonderful conference, and to the membership and trade supporters and sponsors.

We have continued with strong advocacy for our members, trainees, and their patients by meeting with the Health Ministers of New South Wales, Western Australia and Queensland in recent weeks, and visiting training hospitals and teams in NSW and Western Australia.

The RANZCOG Foundation is our College's philanthropic arm that supports education and research through scholarships and grants to local and international applicants. For our time-poor members or those with limited opportunity to contribute, a tax deductable donation to the Foundation will go a long way to assist it's many endeavours; read on for a QR code.

To those members of our College community who have and will continue to volunteer their time and expertise to RANZCOG activities – thank you!

To those who are considering involvement, please reach out, become engaged with our RANZCOG community, and help this and the following generations of our profession.

Please have a safe and happy summer and festive season, and see you in 2023!

From the CEO

Vase Jovanoska
Chief Executive Officer

Welcome to our final issue of O&G Magazine for 2022, and what better theme could we have to finish the year, than Community. This year has been all about community and reconnecting after the past few years of isolation, distance, and disconnection from one another. As an organisation, we have also come together as a community in many ways this year and we have had so much to celebrate and acknowledge.

Recently, College staff from across Australia and Aotearoa New Zealand had the chance to participate in our first staff **Professional Development Day** at Djeembana. The theme of the day was 'Connection to Place, People and Purpose'. It was lovely to hear from RANZCOG members about their experiences and work with the College, to reunite with one another, and to connect with our new location, Djeembana, on Boonwurrung land in Naarm.

In Aotearoa New Zealand, in August, our **Annual Scientific meeting in Christchurch** was the first opportunity in quite some time for the O&G community in New Zealand to come together. The two-day event was attended by around 150 people and the theme focused on 'doing things differently' and 'tū ora mai' ('live in health') – what a great message and theme that is considering the last few years we have had.

In September it was also a pleasure to see our **Aotearoa New Zealand Women+ Health Summit**, with the theme 'Flourish', connecting us with the wider community of people with an interest in women's health. A community event run by the College, the summit brought together our partner organisations and people from a wide range of perspectives including medical, consumer and government, to have meaningful discussions that will contribute to the development of an Aotearoa New Zealand Women's Health Strategy.

We had the opportunity to engage with our First Nations members and trainees at the **Australian Indigenous Doctors' Association (AIDA) Conference** in the Yugambeh region of the Gold Coast between 4–6 October. We heard from some inspirational speakers and met with prospective Indigenous doctors to our O&G workforce.

Our **Annual Scientific Meeting** was held the week after AIDA, on the Gold Coast between 7–12 October, and boasted a huge turnout, with over 1,000 delegates in person as well as 246 virtual delegates in attendance. At the Presentation Ceremony, 88 new Fellows, subspecialists and RANZCOG award recipients were joined by their families and friends to celebrate their achievements.

The College's **Consumer Network** and **Consumer Network Working Group** are initiatives that were developed in 2019 for RANZCOG to engage with and gain valuable insight and feedback from consumers about the services provided by our members. The Working Group is made up of many consumer representatives from the community who meet throughout the year to discuss topics in women's health that directly impact them, and how we can improve upon these services through the work of the College. Our consumer representatives also sit on many committees and working groups at RANZCOG to provide valuable insight that informs our work.

As part of this, a series of webinar topics for RANZCOG were hosted in 2022 and a **consumer-based webinar series** was run throughout the year. Issues for discussion have included vaccination and pregnancy, and since our last edition of O&G Magazine, perimenopause, contraception, sexual health, and fertility. These webinars connected our member and consumer communities together to discuss health topics in a consultative and informative way. We look forward to the 2023 series to further facilitate these discussions, and strengthen the relationships between consumers and practitioners.

We are currently preparing for another **election year** – how time has flown! In 2023, the incoming President will be announced in March, following a formal election process. We will also see the announcement of members to the 13th College Board in July, completion of tenure of the 12th College Council, and a new membership across our committees and working groups from November.

As I have previously reported, 2023 is an important year as RANZCOG is due to submit our **Reaccreditation report** with the Australian Medical Council (AMC) and Medical Council of New Zealand (MCNZ), assessing the extent to which the College meets accreditation standards for its FRANZCOG, subspecialty, CPD and SIMG programs. The AMC will assess the College's written submission, observe the College's exam format and integrity, and operational aspects. College stakeholders (trainees, supervisors and external stakeholders) will be invited to comment on the College's training programs, and visit a number of training sites to gather feedback from key hospital stakeholders. The AMC will also visit the College during the July 2023 Council week, to meet with relevant committees and other key stakeholders involved in College governance. I look forward to providing more information on this in early 2023.

As 2022 draws to a close, we can all reflect on what has been a year of change and adjustment for us all, but one that has been positive and has allowed us to feel part of our communities once again.

I thank the College Board, President Dr Ben Bopp and our Council as exemplary leaders, as well as our committees, all our volunteers, and our dedicated College staff across Australia and Aotearoa New Zealand, for the work you continue to put in with dedication, commitment and respect for each other.

We have a wonderful community at RANZCOG and I am proud to be part of it.

I wish you a safe, happy and fun festi

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

Cherisse Buzzacott
Midwife

In this edition of Leaders in Focus, I speak to midwife, Cherisse Buzzacott, a proud Arrente woman from Alice Springs, NT.

I 'found' Cherisse on Twitter @sistercherisse (I recommend social media for making connections with people one may never meet in person in our busy lives. My experience of sending DMs to like-minded people has been overwhelmingly positive and great for my own learning and understanding of many tricky issues). Cherisse was truly generous despite the many pressures on her time as a leader, midwife and mum.

Cherisse's journey in midwifery has taken her from Alice Springs to Brisbane, Melbourne and Canberra in various roles. She was employed by the Australian College of Midwives (ACM) as the Project Officer for the Birthing on Country (BoC) project and co-chaired the Birthing on Country Strategic Committee. She is the current Chair of the Board of Trustees of the Rhodanthe Lipsett Indigenous Midwifery Charitable Fund (RLIMC).

Readers of this magazine need no reminding of the gap that exists between pregnancy and birth outcomes for First Nations women as compared to non-Indigenous women. In recent years, the effect of racism rather than race as a risk factor for poor maternal health outcomes has been under the spotlight across the world. Research from the Centers for Disease Control and Prevention (CDC) in the USA shows that black babies are three times more likely to die in the hospital than white babies, when cared for by white doctors. This disparity halves when black babies are cared for by a black doctor showing that race concordance means that healthcare professionals are more attuned to social risk factors and cumulative disadvantage. In Australia, RLIMC was established as a scholarship fund by ACM in 1996 and renamed as RLIMC in 2005. The express aim of this organization is to contribute to Closing the Gap by providing assistance to First Nations people who are training to be midwives, to increase their numbers and enable provision of culturally concordant care for all First Nations women and families.

I hope readers will find this interview inspiring. You can support and follow Rhodanthe Lipsett Trust on all social media platforms as well as donate via their regular online giving platforms across the year.

You can follow Rhodanthe Lipsett Trust on Facebook at **facebook.com/FirstMidwives/** and Cherisse on Twitter **@sistercherisse.**

Could you please tell me about your childhood and early years? What or who influenced your decision to train in midwifery?

Growing up, I was always influenced by the strong Aboriginal family members who raised me. They were working in health and education amongst other careers. My parents had said that I might one day work with my people to try and improve challenges that are faced by Aboriginal people in Mparntwe (known as Alice Springs) as well as those people living in remote communities. Health was a big focus for me as I knew I wanted to work in health.

My mother wanted to do nursing but had me when she was young, so I think that was inbuilt in me to work alongside First Nations people as either a doctor or a nurse. I never fancied working alongside sick people and even now am not great with health issues outside of pregnancy or childbirth etc. When a university tour came to my school I first heard about midwifery. I thought it interesting working alongside mothers and babies, but over my senior years of schooling became more knowledgeable about midwifery and wanted that to be my career focus. I knew it was a way I could contribute back to my community using some of the insights and aspirations my family showed me along the way.

What is the Rhodanthe Lipsett Trust?

The Rhodanthe Lipsett Indigenous Midwifery Charitable Trust was set up in 2014, in recognition of Dr Rhodanthe Lipsett OAM, who had a passion for supporting Aboriginal families across the span of her career as a midwife, author and advocate and in recognition of her support of the Australian College of Midwives (ACM). The Trust gives scholarships for First Nations student midwives and First Nations graduated midwives who have an interest in professional development opportunities.

The RL Board is made up of 8 First Nations midwives, all with an interest and professional focus on birthing on country, teaching, research, workforce development, advocacy and First Nations maternal health to name a few things. I have been the Chair of RL since 2018. A number of key partnerships have supported us, namely Kimberly Clark Corporation, with Huggies Australia, giving support and generous donations for the lifespan of the Trust. We are a not-for-profit and rely on donations and fundraising efforts of midwives and supporters across Australia.

What is Birthing on Country and why is it important?

Birthing on Country is a metaphor for First Nations birthing practice and incorporates culture and the traditional skills of our old people. It is not to do with birthing in a physical location, as often women and birthing people are removed from traditional lands for many reasons since colonisation, but it is about the essence of everything First Nations people hold in their culture, living, family and how they use that to empower birthing and pregnancy.

All First Nations women have the right to access culturally appropriate and culturally safe care, in a hospital or in the bush. As midwives we learn about choice and informed consent; those things are often few and far between for women and people in my community.

A paper by CRANAplus, Australian College of Midwives and Congress of Aboriginal and Torres Straight Islander Nurses and Midwives describes the early insights around birthing on country[1]. There is so much work being done, and there are so many amazing First Nations midwives, organisations and researchers who are leading the way.

Why is it important for more First Nations women to train in midwifery?

The difference it makes having a First Nations midwife when you're a First Nations woman, is immeasurable. We need more First Nations midwives to ensure the safety and wellbeing of women and families. To be able to develop trust and confidence in the person that is caring for you is so important at a vulnerable time in someone's life. Having a First Nations midwife eradicates much of the uncertainties, brings forth concerns and wishes of women when needing to form relationships, and creates hopes to have care that is non-biased and free of judgement. Many of us midwives know the lives, and experience the culture, of those First Nations women and people that we care for.

As midwives, we also work across all platforms in teaching, education, and research; we need to be the ones driving the issues that affect us and our communities during pregnancy and childbirth as we know the problems and the solutions. We know our people best and can provide an experience that surpasses any other because we live and breathe the same beliefs. Although they differ among nations and language groups, we have an acceptance and forethought to cater to families and the wellbeing of their new baby.

What can our readers do to engage First Nations women in pre-pregnancy and pregnancy care?

It's all about trust and honesty, working towards a common goal (healthy baby, pregnancy etc.) and ensuring that you have used every tool accessible to allow the woman or person to have a say in their maternity healthcare plan.

It's ensuring the high-quality service you're providing is shared throughout the whole of the service, including all clinical staff, staff in admin, cleaners and anyone else who may be involved in the care. It is crucial to ensure there is transparency and a common goal of supporting First Nations families, free from judgement, and individualised to each family. Cultural First Nations mentors in the workplace can support this, as well as regular reflections and consumer feedback.

What does a typical day look like for you?

I am now working for an organisation called Children's Ground (childrensground.org.au), a First Nations-governed Aboriginal not-for-profit organisation, that seeks long term change to Arrernte people in Mparntwe. I work as the Head of Health, overseeing health promotion and health support for my team, working alongside early-years educators. We have an all-of-community response and include teaching and sharing of Arrernte language and culture.

I am returning to midwifery in December this year, after six months away. A typical day for me is usually up early, getting my three boys ready for school and day-care, dropping them off and then attending work. As a midwife I was working in shift work and was finding the balance as a mum and midwife difficult, hence making the transition out. I am always in daily contact with my Rhodanthe board and am typically setting up late afternoon Zoom meetings with donors, or writing papers for journals, as well as planning for board or partnership meetings. I spend my day meeting with stakeholders and supporting staff on the best ways to improve the health and wellbeing of my people, the way that I was taught.

I am blessed to work alongside my Arrernte Elders and share culture and language with them, as well as attend on-country learning, which is every few weeks. I am expanding my knowledge in health but will always be a midwife to my core.

What have been the highlights of your career?

There have been so many highlights in my career. The biggest reward for me will always be being a part of the birthing journeys for a number of my family and friends who I have supported over the years.

Becoming the Chair of RL and leading it to the successful organisation it is today is also big on my career highlights.

I have participated in events, conferences, interviews, written for journals, published my own articles and written for a chapter in a book to be published in 2023, so I can't credit one thing as being more superior than the rest of the things I have been involved in over the years. There is definitely more I want to achieve so this could change.

I would say meeting and interviewing Cathy Freeman on two occasions, as an Aboriginal girl who grew up admiring her amazing talent, was top tier. I told her and others that I've achieved my peak... not entirely true, as I said there is more to come, more I must learn and more I can share throughout my life.

Have you faced racism in the workplace? How have you dealt with it?

I have experienced bullying and backhanded racist comments not directed at me. I can say the bullying by a team leader midwife (non-race specific) affected me more than the racist comments.

I did see racism and discrimination towards First Nations women leading to a lower standard of care being provided. I witnessed this daily as a student and it drove me to seek clinical placements elsewhere to interstate hospitals, thinking I would see improvements. The comments I heard were from patients and their families, that derogatory names had been used that are harmful to First Nations people. In each instance, I knew this was a moment of education and often spent time talking to mothers and families (if appropriate) when these occasions would happen. Working in Melbourne in a large hospital where many cultures met within the hospital made me realise that this is often more about under-exposure to First Nations people and the influence of what they had heard and saw in the media affecting their ideas about my culture and community.

The racism I experience as a First Nations woman is far different; this was and still is a regular issue when I access health care for myself and my kids. The disregard for our needs is huge but will never be dealt with in a system that was not designed for us, without our input into the policies and services. Therefore, we will not see change unless we are redesigning our own health care provision, like that of birthing on country services.

What are some of the barriers you have faced as a First Nations woman in leadership?

One of the most recent issues has been the disregard of my knowledge and expertise as an Aboriginal woman. Being overlooked for certain tasks or roles where First Nations maternal health is at the forefront, not having been invited to speak or share alongside non-Indigenous colleagues. It's also the afterthought that they need to include a tokenistic Black voice, let's reach out to Rhodanthe or myself at the last minute for an opinion or review of something that has been developed but without us included. Those are the challenging moments for me.

Then on the other hand, like many First Nations women, there's the expectation that we know all, and it is our job to teach others. This is not the case. I know about my culture and some of the women I care for, but I don't pretend to know everything. It's not our role to educate or answer as the only Black midwife in a hospital. It's the unpaid and unrecognised free labour that I am often lumped with.

How do you achieve work-life balance?

I will be honest and say that I don't. Every day is a challenge and if not for my supportive family, I would not be able to do the work that I'm doing. The last six months has seen a slight shift towards better care of myself, and learning to say no when things come up.

I have an amazing RL Board who I can delegate requests to and are supporting me in my role as Chair. This is something I am working on, and I think because of my work and the person I am I find it hard to turn away when opportunities come up where First Nations maternal health is at the centre.

My kids recognise my work, and I am lucky that the organisation I am currently working for allows for family support and flexibility. My kids are with me at every chance and are included in everything. They are learning the culture and language and I am glad for it. There is a lot of time that goes unpaid or unrewarded, but I feel it's the work that needs doing and I know I can, so I do. If anyone knows the secret to achieving work-life balance, I will gladly pay to learn.

Cherisse Buzzacott

If there was one thing (or three) that you could change in maternity care to make it safer for First Nations women, what would it be?

This is the most challenging question you have asked me – to name three of a hundred things!

1. Birthing on Country services
2. Remote birthing services to be established, or better support to women in remote areas
3. Embedded, regular, and compulsory cultural safety training for all health care professionals and employees, including high level management/CEO to cleaners and laundry staff.

What gives you hope and optimism for the future?

The First Nations student midwives that engage and apply for Rhodanthe scholarships each year makes me excited and hopeful for change. That First Nations midwives are fundraising, applying for scholarships and seeking out further professional development opportunities makes me happy to know there are midwives coming up that are not just here for being a midwife but have the passion and drive to make a meaningful change in their communities, improving lifelong health and wellbeing for next generations.

It's the people I see at CATSINaM (Congress of Aboriginal and Torres Strait Islander Nurses and Midwives) conferences, during breakout sessions, as we chat, that make me excited about our future. Among all the things that go wrong, I see small changes that are hopefully making a big impact in someone's life.

My kids inspire hope; as they learn and grow, I am challenged and excited about the opportunity to mould them in the way that I was shaped to be who I now am.

References

1. Effect of a Birthing on Country service redesign on maternal and neonatal health outcomes for First Nations Australians: a prospective, non-randomised, interventional trial. Available at: https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(21)00061-9/fulltext

Get to know College staff: various LIDT members

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 once again focus on the Leadership, Innovation and Development Team (LIDT), which comprises the senior leadership of RANZCOG. Featured here are more members of the LIDT: please refer to previous issue for additional members.

The LIDT share information about each business area with other leaders, including new projects and initiatives that may impact other units, discuss current and future operational challenges and communicate shared information in a consistent manner with their teams and direct reports.

Sabrina Hanna

Head of Strategic and Cultural Initiatives

Working with stakeholders across the organisation, Sabrina is responsible for the drive and oversight of the College's cultural and strategic initiatives including delivery of our gender, equity and diversity projects, consumer network initiative, cultural safety and First Nations projects. Her team is also responsible for putting together the College's formal submissions to various external stakeholders.

During her three and a half years at RANZCOG, Sabrina also worked as the Head of the Executive Office, responsible for the oversight, coordination and process improvement of many administrative aspects associated with the College's Board, Council, President and CEO.

Sabrina was part of the team responsible for the sale of College House in Albert Street, East Melbourne, as well as our relocation to Djeembana in Melbourne.

Sabrina has worked across the corporate and not-for-profit sectors over the past 15 years in industries such as education, allied health, sports and fitness, public relations, and advertising. Sabrina holds a Bachelor of Arts in Mass Communication (Public Relations and Journalism).

Mark Beaves

Head of RANZCOG Quality Assurance Programs

Mark is a registered nurse and midwife and has been the manager of the Fetal Surveillance Education Program (FSEP) since its inception in 2003. Mark has recently taken on the role of Head of Quality Assurance Programs, including the FSEP, Nuchal Translucency and Colposcopy programs.

The Nuchal Translucency, Ultrasound, Education and Monitoring Program (NTUEMP) audits the performance of the fetal nuchal translucency scan.

The Cervical Quality Improvement Program (CQuIP) aims to improve the care of women referred for colposcopy and treatment of abnormalities.

The FSEP provides education for fellows, GPs, midwives, and trainees in interpreting fetal heart rate patterns, aiming to reduce adverse outcomes. Mark and his team of 12 clinical educators travel across the Asia Pacific region delivering up to 350 lectures per year.

Mark has 20 years' experience in the maternal fetal medicine unit at Monash Health, holds a Bachelor of Education, and is undertaking a PhD through Monash University. Mark attributes his high golf handicap to his penchant for fine red wine.

Jacky Heath

Head of Learning and CPD

Jacky leads the Learning and Continuing Professional Development (CPD) unit within the Innovation, Learning and Quality Assurance Directorate, providing strategic leadership for the RANZCOG CPD program, ACQUIRE eLearning, educational resource design/development/evaluation and operational management of the College's educational programs for members.

With a Master's Degree in Education, Jacky has worked extensively in the tertiary education sectors, in the UK as a teacher, and in a number of senior leadership roles. Since arriving in Australia in 2006, she has worked in the vocational education and training sector, helped establish a registered training organisation, and designed programs for the Diploma in Management and the Certificate IV in Training and Assessment.

At the Royal Australasian College of Surgeons, Jacky led the Prevocational and Education department, with responsibility for developing the Junior Doctor Framework (JDocs), managed surgical education and training, and supported the project team for the Building Respect Action Plan. Following a contract role at the Royal Australian College of General Practitioners to assist with implementation of their CPD strategic plan, she commenced at RANZCOG in January 2020.

Anna Smaragdi

Events Manager

Anna leads the Events Team of the College. Her role includes managing four staff and supervising the planning and delivery of the College's mid-scale and major events which include: the Annual Scientific Meeting, the Regional and State & Territory Symposia, the New Fellows and Awards Presentation Ceremonies and the Women's Health Summit. In addition to events, Anna's team delivers activities that relate to the regional and rural cohorts of the membership, such as the Practice Visits, Clinical Webinar Series and matters relating to governance, workforce and training of our regional members. Anna also heads the Events Strategy Working Group and other internal groups in an effort to streamline event-related processes and align the College's events portfolio with the RANZCOG Strategic Plan.

Anna joined the College in 2014 following a career in film, tv and event production in Greece. Since commencing her career in the industry in 2004, Anna has taken on various roles including stage manager, location scout, assistant director and production manager for television shows, films, ad campaigns, and corporate events.

Anna has a Bachelor in Theatre Studies and is also a member of PCOA, Associations Forum and PCMA.

Jude Kaveney

Training Delivery Lead

Since joining RANZCOG in 2006, Jude's role has evolved from conference planning to becoming a specialist in all things related to the FRANZCOG Training Program.

Based in Wellington, Jude is currently responsible for overseeing the delivery of RANZCOG's training program in Aotearoa New Zealand. She has supported many New Zealand trainees through their training journey.

Jude is also an advisor to New Zealand Training Supervisors and is a key resource for the New Zealand Training and Accreditation Committee, in ensuring the quality of training in Aotearoa.

Jude also has functional leadership of FRANZCOG training across the State and Territory Offices in Australia, supporting the State and Territory Manager. Jude works closely with Training Programs and the State and Territory teams to deliver and develop high quality FRANZCOG training across both countries.

Jude has previously worked in management roles in several not-for-profit organisations.

She holds a Bachelor of Horticultural Science.

Editorial

Sarah Ortenzio
O&G Magzine Editor

com·mu·nity
NOUN
1. *a group of people living in the same place or having a particular characteristic in common*

In this Summer issue of *O&G Magazine,* we're celebrating community, in all its different configurations. As members, you're part of the RANZCOG community. As doctors, trainees, Diplomates, Fellows, specialists, subspecialists, you may branch out into further communities. Further, you all contribute to your own communities and serve various others in your work. Community is also found within your culture, identity, hobbies and, quite simply, within the area in which you reside.

Community is a place to be understood, supported and accepted.

One of the many things the last few years have taught us is the importance of community.

Our College and members do so much for our community, our respective communities and volunteering in global communities.

In this issue, we touch on the incredible importance of the First Nations community with Cherrise Buzzacott in Leaders in Focus, and we will explore First Nations and Māori cultures in more depth in our upcoming People of the Land issue.

We explore the different roles the College plays in the community – rurally with the OGET project, broadly with the Consumer Network Working Group and by supporting the important work of our members with Scholarships and the RANZCOG Foundation.

We have two orations which celebrate the lives of Brian Spurrett and Arthur Wilson. Their incredible work and dedication benefited various communities, and they have both left a legacy that ensures this important work continues.

There is also an important address from our Past President, Dr Vijay Roach, on the significance of inclusion.

As you read this issue of *O&G Magazine*, it is a great chance to reflect on all the varied communities you either belong to or work within. It's also an opportunity to consider communities for which you may have little exposure. We all need our communities; to be understood, supported and accepted.

The cost of 'othering'

Dr Vijay Roach
FRANZCOG
RANZCOG Immediate Past President

This is the full version of the Past President's speech delivered at the RANZCOG Annual Scientific Meeting, held on Australia's Gold Coast in October 2022. The full title is 'The limitations of a narrow definition of normal and the cost of 'othering.'

Good morning. I respectfully acknowledge the Kombumerri families of the Yugambeh language region, the traditional owners of the land on which we meet, and pay my respect to their elders past and present, and all Aboriginal and Torres Strait Islander Peoples here today.

I reaffirm my commitment to the reconciliation journey, because at its heart, reconciliation is about strengthening relationships between Aboriginal and non-Aboriginal peoples, for the benefit of all Australians. RANZCOG is a bi-national College and I recognise Maori as tangata whenua in Aotearoa New Zealand and our obligations as Te Tieriti O Waitangi partners

Recognition of all First Nations people is a good place to start when talking about culture and the impact of defining "normal". We have become so used to commentary on the health outcomes for Māori in Aotearoa, and Aboriginal and Torres Straits Islander people in Australia, that there is a huge risk that we will allow this inequity to continue. Sort of business as usual. For many years we have tinkered at the edges. To bring about meaningful change requires significant disruption, radical thought, commitment, financial resources and personnel. It requires a First Nations workforce that is empowered to lead and make meaningful decisions. It requires an attitude from society and the medical profession that there are different ways to deliver healthcare and a willingness to listen rather than instruct. It requires the dominant culture to step back and support self-determination.

Einstein demonstrated that if we look at anything through a different lens, what we perceive will be different. In his example, he used a moving train through the perspective of two different people. One person who is sitting on the train, the other standing outside of the train. If lightning strikes the train at both ends, the person standing outside will say the bolts were simultaneous because the light will hit their eyes at the same time. However, the person sitting on the train who is facing towards the front of the train will say that lightning strike from the back of the train came afterward because the light wouldn't reach their eyes until after the strike at the front of the train happened. Both perspectives are true, but it depends on which lens you're looking through – it's all relative. His theory mainly applies to physics, but we can also apply this to life as well.Why is that I look at the world one way and someone else sees it so differently? My talk today isn't specific to obstetrics and gynaecology. We are more than obstetricians and gynaecologists, general practitioners, midwives, nurses, students, College staff. We're people on the planet, part of the fabric of society, and what we say and do makes a difference. What I want to talk about today is what it means to be part of the dominant culture and what it feels like to sit outside that.

For those who are members of the dominant culture, to begin with, this discussion doesn't make sense. They know their place. They know that they belong. What does it feel like if you don't belong?

The Italian philosopher Antonio Gramsci developed the concept of cultural hegemony out of Karl Marx's theory that the dominant ideology of society reflects the beliefs and interests of the ruling class. Gramsci argued that consent to the rule of the dominant group is achieved by the spread of ideologies – beliefs, assumptions, and values – through social institutions such as schools, churches, courts, and the media, among others. These institutions do the work of socialising people into the norms, values, and beliefs of the dominant social group. As such, the group that controls these institutions controls the rest of society.

What does that mean in English? It means that if a powerful group keeps on stating what is normal, then that becomes the truth. It's normal for men to be in charge. It's normal to wear Western clothes and 'exotic' to wear a sari. It's normal to birth in a hospital and 'alternative' to birth at home. Christianity is normal and every other religion is different. If you're not white, then you're grouped as a 'person of colour'. Has anyone thought about an expression 'person without colour'?

Cultural hegemony is most strongly manifested when those who are ruled by the dominant group come to believe that the economic and social conditions of their society are natural and inevitable, rather than created by people with a vested interest in particular social, economic, and political orders. In other words, we all get sucked into it, and even those who are disenfranchised accept the situation.

If you're white, wealthy, educated and healthy it makes sense that the way that you view the world is the way that the world is. Unconscious bias isn't a moral failing, but it is an impediment to the way that we interact with other people. Do you cross the road when you see a big Māori man coming towards you? Do you assume that a woman wearing a hijab is uneducated and dominated by her husband? Do you think that an obese person is lazy, eats junk food and is less likable? When I was growing up there was a narrative that Indians had lots of children because many would die, and they were ok with that. Until very recently we genuinely believed that a man in a wheelchair couldn't be a doctor.

While I was writing this talk, I repeatedly asked myself why was I writing this talk and what did I hope to achieve? As I get older, I visualise a photograph of my life, my history, my culture, and the story of my family. Slowly I see that photograph fading until eventually there is no record, no memories and that my history has dissolved into the history of white Anglo-Saxon Australia. At the same time, I reflect on my own privilege. I've had the benefit of being born in Australia, education, wealth and good health. I've been assimilated into the dominant culture because my accent's acceptable and I enjoy a beer and a pie and cricket. Where I am now is a result of that privilege.

So what I wanted to try to convey today is the importance of challenging ourselves. And this challenge is for every one of us. Every person is at risk of othering others. It's a mistake to think that because you're not white, because you're female, because you're gay or have cerebral palsy that the default to othering doesn't apply to you.

But the reality is that the dominant gender, the dominant races, the dominant religions and the dominant sexes do have the most impact. It's a logical fallacy, false equivalence, to say things like "it's hard when I'm the only man in the group" or "it was tough for those on the First Fleet too" or "I'm the only white person here."

Othering is often subtle and may involve unconscious assumptions about others. For example:

- Attributing positive qualities to people who are like you and negative qualities to people who are different from you
- Believing that people who are different from you or your social group pose a threat to you or your way of life
- Feeling distrustful or upset with people of a social group even though you don't know anyone from that group
- Refusing to interact with people because they are different from you or your social group
- Thinking that people outside your social group are not as intelligent, skilled, or as special as you and your group
- Thinking of people only in terms of their relationship with specific social groups without giving any thought to them as individuals

So now that we've identified the issue, where do we go from here? Is it all hand-wringing and guilt? Are all white people, all men, all heterosexuals bad? Let's not give in to that. That's a weak and gutless response. First, we need to accept that the argument is true. This is a real issue. We need to accept that people genuinely are othered and suffer from racism, sexism and every other form of discrimination. It's true. It's real and it's deep. Then, rather than responding defensively, we need to be open to saying "oh...I didn't realise that I was thinking that way" or "I wasn't aware of the impact of my words, actions, behaviour". We need to seek guidance, to be open to change, willing to challenge our premises, confront our unconscious biases.

If we're going to change the paradigm, some of that journey is going to be uncomfortable. Nobody likes conflict or confrontation, but we can't just hope that things will change through wishing for it. Those of us who have power will have to accept our responsibility to speak up when we observe biased behaviour. People are less likely to engage in othering when it is socially unacceptable. When the powerful don't speak up, it becomes more acceptable to engage in those same types of behaviours. I don't want to stand up here like some holier than thou preacher telling everyone else what to do and say. But I've thought about that and decided that it isn't ok to be in a powerful position and not to speak up. That's cowardly and disingenuous. Importantly, the powerful must not speak for others. Rather we should stand alongside them. And we should listen when they speak for themselves.

The biggest barrier to moving to a society that increases equity for all is that the naysayers cast the argument through a deficit lens. If we allow same-sex marriage it will lead to a breakdown of social order. If we enshrine an Indigenous Voice in the Constitution we will lose all of our land. If we have affirmative action for women all the men will lose their jobs. If patients have a say in how they want to be informed and cared for, no-one will listen to doctors and we'll be the ones who get sued when it goes wrong. An Indigenous person just got the job because they were given a leg-up.

Another push-back is "what am I supposed to do?" and "you can't even compliment a woman on her looks anymore" or "how am I supposed to tell if they're a he or a she?". Seriously? Well, I'm sorry that you're having a rough time. I'm sorry that you have to pause and think. What if I put it another way? Did any person ever walk away, having hurt another person, intentionally, or not, and feel good about it? I didn't think so.

The beauty of diversity and inclusion is that I can finish on a positive note because this is a positive story. Did any person ever say a kind word, show compassion, or respect, and regret it? Rather than seeing inclusion through a deficit lens, we can reflect on how much we've missed out on through exclusion, and how much there is to gain through full and equal participation. For all of human history we have missed out on 50% of the population. How those women suffered but how much opportunity was lost. If we exclude others from full participation, we all miss out. Imagine music with just one beat, food with just one taste, a picture with just one colour. Imagine if all accents were the same, if we all looked the same, if we didn't need to go through a process of listening and understanding, growing and learning. Equity is not just about letting the other person in. It's about creating an opportunity for ourselves and for society as a whole.

I think that our College is moving in that direction. We need to keep talking about it. We need to keep pushing and reminding ourselves. I believe in the inherent goodness of people and we are good people. Let's invite everyone to the party. That's the first step. The next step, when they come to the party, is to reach out, and ask them to dance.

The role of community in women's health

Laura Simpson
Member
RANZCOG Consumer Network Working Group

Tessa Kowaliw
Member
RANZCOG Consumer Network Working Group

One of the gifts to come from being actively connected to the women's health space is discovering the beautiful people who hold it together. As girls enter womanhood, become pregnant and birth babies, navigate perimenopause, and possibly face reproductive challenges or encounter illness along the way, it is gynaecologists, obstetricians, midwives, doulas, educators, advocates and consumers who – among others – form the rich community of support which complements the delivery of care.

Some of us choose to do this in ways which have direct connection to the women we serve, either as care providers or as consumers building discrete communities around specific interests and needs. For example, whilst Laura and I became friends courtesy of the RANZCOG Consumer Network Working Group (CNWG), we also share an interest in VBAC (Vaginal Birth After Caesarean), having each found a lack of independent information and support whilst making decisions about our next births after a caesarean. We are both members of the VBAC Australia Support Group, a national closed Facebook group which is a community of 17,100 people whose experiences, insights and perspectives are at our fingertips as group members. I also created a similar online group, 'VBAC Chat: South Australia', in 2016 to offer a community 'within reach' to women who want access to local knowledge and information. I remain the key admin, and the group continues to run and grow today, clearly addressing an ongoing community need for peer support. Within both spaces, it is the wonderful mix of consumers, doulas, midwives, allied health professionals and obstetricians who volunteer their time and good will to others which enables these communities to remain active, dynamic and alive.

Whilst VBAC brings Laura and I together, a multitude of consumer-run Facebook groups and organisations exist for other health topics, such as menopause and perimenopause, vulval, uterine and endometrial cancer, birth trauma and injuries, rural O&G, peri/antenatal mental health, and homebirth. The Australian Birth Trauma Association (ABTA) online group is run purely by volunteers to create peer-to-peer community support across Australia for when users need it the most – yet another example where community programs like this are a valuable resource for metropolitan and isolated consumers.

On other platforms, such as Patreon, TikTok and purpose-built apps and fora, there are a vast number of special interest women's health groups to join, either via membership or ad hoc conversation. As our lives become busy and the face-to-face meetups of previous years become harder to both organise and attend, online communities are increasingly providing peer support, education and information to women's health consumers in a format which is easily accessed and shared. Having a world of support in one's hand is truly the modern way to build the village we need as women and mothers navigating the world, and our bodies within it. Indeed, RANZCOG's Consumer Network Working Group held its first hybrid meeting on 7 November 2022, recognising the value of a mixed format in allowing consumers to participate in and around their location, family schedule and other life pressures. RANZCOG also makes a range of information available to the consumer community through online channels, such as Patient Information Pamphlets (available on the College website).

The online community (http://ranzcog.edu.au/resource-hub/?resource_audience=for-public) is just one channel for community building and contribution, and its value is sometimes only apparent in real-life application. Thus, to truly demonstrate the concept of the online women's health community in action, we asked our online networks – including the RANZCOG Consumer Network Facebook group – 'How do you do community in women's health?' And, in the true spirit of community, we present a selection of answers – some received across Facebook, LinkedIn and TikTok, and others captured during our CNWG hybrid meeting – so that you can 'hear' the diversity and richness of our collective community voice.

How do you do community in women's health?

"I do presentations with women's groups of my own vulva cancer experience so others can learn preventative knowledge and build confidence within themselves that it's now ok to open conversations about Gynaecological and related mental health without stigmas."

– Kath

"I work with women on their health and fitness journeys, I share women's health information, I am a petitioner to the NZ government on improving our rehabilitation for mothers."

– Kristy

"Community 2022 [is] accessible 24/7, understanding and with the ability to listen; someone who is there for you with no judgement. I have found the value of online communities, along with my local community of friends, invaluable. For me, building community means giving back to what you take from. Working together to create a cycle of support when people need it the most."

– Laura

"I am grateful for the communities of VBAC, homebirth and local birth advocates etc. which exist online. It gives access to information and insights from other women, particularly those who have been there, done that... Such a powerful way to find context when making decisions about what care to seek and/or receive in women's health."

– Tessa

"I am part of an active women's health community in the form of being a member of support groups for women suffering from pelvic organ prolapse. The understanding, shared experiences, support and compassion shown is invaluable. It has given me the courage to share my journey publicly to raise awareness this condition."

– Bronwyn

"I am a doctor and a women's health advocate since completing med school about 5 years ago. I have worked for a pregnancy and parenting app where I led a team of doctors and worked towards reaching maximum rural Indian women and spread [sic] women's health awareness in such regions through the Live sessions. I now have my own YouTube and TikTok channel with Hindi Women's Health content with over 290k followers and more than 30 million views. I also currently work with Waterwell project and host some of their women's health sessions for migrants, refugees and asylum seekers. Currently, I am working on creating women's health awareness content in different languages and hope to improve awareness at a global platform."

– Sumaiya

"My Birth Map encourages preparation for birth and beyond. Building community means being aware of groups and support networks nearby and online. A 'gathering of supporters' in pregnancy helps set this up. This involves recognising the needs and values of the new family, acknowledging the mother-baby dyad and honouring matrescence."

– Catherine

"A woman I met through the Women Services Network and I went, together with a filmmaker and a GP, out to the local community centre and we got young women to express, in their own words, why to get pap smears."

– Georgia

"You would not believe how much I have learned and normalised about my body from TikTok. Friends, friends who are health professionals, all help, too."

– Deb

"It's not about "Will fish oil help my arthritis?". It's about what brand do you take, where do you get it, who's the cheapest, and how do you store it, and - most importantly - how do you feel and how are you coping? Health communities around specific conditions are so important."

– Fiona

"It's about strengthening and building knowledge and access to resources through shared language, hobbies and food. We often make birthing kits or health packs over an afternoon of tea, cake, catching up with friends and working towards a common goal."

– Emily

"Lived experience and joining other community groups within my capacity as a consumer rep to understand community needs."

– Keshala

"It can be very isolating to be constantly advocating for my health needs, so it is great to move to some more structured advocacy together with others"

– Tara

"Employment pathways for non-clinical lived experience contributors, e.g. in research projects; and cisgender and transgender women working together."

– Julian

"I do community by firing women up to ditch the patriarchy and build each other up. I love facilitating groups where women are supported to step deeper into their power and to encourage each other to share their magic."

– Lizzie

The OGET project

Lisa Egan
OGET Project Coordinator

Mel Pietsch
Head of Engagement and Rural Health

The Obstetrics and Gynaecology Education and Training (OGET) project is currently a 12-month Australian Government funded pilot to develop and deliver upskilling and educational training for a range of medical professions who play a role in the provision of maternity and maternity related services. The pilot is being delivered via four hubs providing on site and outreach training to rural and remote areas of Australia.

The hubs are located at:

- Royal Darwin Hospital, covering the Northern Territory and northern Western Australia.
- Orange Health Services, covering their peripheral area of Mudgee, Cowra, Parkes and Forbes
- Warrnambool Hospital, covering Hamilton, Colac, Portland and Camperdown.
- Sunshine Coast University Hospital, covering Gympie and Kingaroy

The project has seen the commencement of hubs visiting their peripheral sites to provide training on topics such as:

- Placenta Abruption
- Primary PPH
- Secondary PPH and sepsis
- Trauma in Pregnancy
- Flat baby at birth
- LUSCS at fully dilated

Participation at each site has varied depending on how regional and remote the location is, with one session seeing up to 21 participants attending.

So far there have been sessions held in various locations including Broome, Western Australia; Gove, Northern Territory; Cowra and Mudgee in New South Wales; and Hamilton and Camperdown in regional Victoria, just to name a few.

Participants that attended the October Broome Hospital OGET session.

Training session run by Dr Andrew Brewin visiting Broome Hospital, discussing the topic of 'Trauma in Pregnancy'.

The project aims to gather evidence on the effectiveness of targeted training in rural and remote areas and to develop upskilling within local hospitals. Reporting and evaluation help to identify further opportunities to improve the quality of education and training provided.

Positive feedback has been received to date from participants, with comments about how they will apply their learnings moving forward:

- 'great refresher; interesting comparison to policy and guideline'
- 'good refresher of management of PPH',
- [that the participant would now] 'escalate abnormal CTG earlier'
- [that valuable learning had included] 'methods of disempacting head' and 'shoulder delivery at caesar'

Participants have also shared what changes or improvements they intend to implement as a result of attending a session:

- 'better awareness of the presenting pattern of PPH and to keep a broad differential in mind'
- 'remembering to refresh on local policy with new drug changes, and immediate vs maintenance management of PPH'.

Another participant said it was 'great to have multidisciplinary views discussed and [I felt] safe to ask questions or offer opinions'. The training sessions have created productive and solid multidisciplinary discussions.

The project has a scheduled OGET Network meeting in late November 2022 which will provide an opportunity to share knowledge, discuss how the project has rolled out, and discuss areas to improve for future opportunities in rural and remote settings.

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.

Without a consistent approach towards providing quality maternity care in these communities, we will only see fragmented and sporadic efforts towards the upskilling and training of medical professionals. It will result in inconsistencies in the access, quality and standard of maternity care provided. We are already seeing promising outcomes from the OGET project, and we look forward to reporting on continuing positive results in 2023.

ARTHUR WILSON ORATION 2022

A decade of progress

Prof Caroline da Costa
FRANZCOG

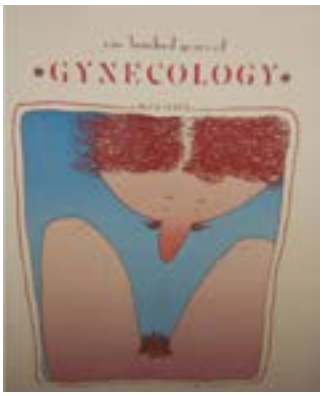
This is an abridged version of the Arthur Wilson Memorial Oration delivered at the RANZCOG Annual Scientific Meeting, held on the Gold Coast in October 2022.

Thank you to the College for the invitation to give the Arthur Wilson Oration for 2022. I was somewhat surprised to be invited to do this as I had already given the Arthur Wilson Oration in 2012. I wondered, did I not get it right the first time, they're making me do it again! However the president has assured me that is not the case.

Dr Arthur Wilson was a prominent obstetrician, a great teacher, and a founder of what ultimately has become RANZCOG. He trained in Melbourne and practiced there from the end of the First World War, in which he served, until he died in 1947 (the year of my birth, so I never met him) and at a time when the practice, and the practitioners, of obstetrics and gynaecology were very different from today's, as you see in the photo below. Here's the young Dr Wilson at Royal Melbourne Hospital, on the left there, around 1920, so a century ago:

In my 2012 talk, I looked at the changes that had occurred between Dr Wilson's time and the first decade of the 21st century, in terms of the gender of obstetricians and gynaecologists, the nature of practice, and the involvement of women in the governance of our specialty and of our College. I also took a look at what the College was like when I joined it as a Fellow in 1981, and I will just share a little of this with you now. Here is the first Council of the Australian College, RACOG, as it was in 1981:

It could truthfully be described as an old boys club – zero gender or ethnic diversity. There was definitely a culture of patriarchy, and indeed casual misogyny, I have to say, in the practice of obstetrics and gynaecology at that time, epitomised in this book cover from 1973, and these china models of mid 20th century obstetricians:



In 1981 I became one of the less than 5% of Fellows who were women, across Australia. The first woman Council member, Ann Hosking, was elected from the ACT in 1984 and she was followed in 1992 by Heather Munro, also from the ACT, and myself from NSW. As a group of just a few women Fellows in those early years, we were very active in lobbying for more women to be accepted into training, and I have to say that there was support from quite a number of male Fellows. There were also huge changes occurring in the world outside the College, which influenced what happened within it. From the mid-1960s through to 1980 we had the second wave of feminism, women increasingly completing higher education and working outside the home, achieving equal pay, building careers, choosing their own lives. We had the availability of the Pill and other reliable contraception. By the beginning of the 21st century, that is after two decades of the College, 50% of the intake into Fellowship training was female, and 21% of Fellows were women, actively pursuing their careers.

These trends continued and by 2012, around 50% of active Fellows were women and 80% of incoming trainees identified as female (and I do note that a number of College members do not identify as either men or women).

From the beginning of the 21st century onwards, more women were also putting their hands up for membership of College committees both in their home states and regions, and for Council. It was a gradual process – even in 2011, all state committees except Victoria were significantly male-dominated, as were the various Council committees, as you can see in Figure 1 – red represents women members and orange male.

The 2012 Council were 25% female; the 2012 Executive included Dr Louise Farrell as the only petunia in the proverbial onion patch. Heather Munro was the first and only woman president of RACOG, elected in 1994. The second woman president, the late Chris Tippett, was elected in 2006 as president of RANZCOG following the merger of RACOG with the New Zealand College. There has been no woman president since; of the nineteen presidents elected since the Australian College was established in 1978, only two have been women. In 2012 there was still a glass ceiling that was intact.

In 2018 there was a definite decision to confront the question of the still decreased equity and diversity within the governance of the College. In November that year the Board established the Gender Equity and Diversity Working Group (GEDWG), of which I am a member, with Dr Gill Gibson as Chair and Dr Kirsten Connan as deputy chair. The Group's first report stated that: 'RANZCOG recognises that being an organisation composed of members with differing skills, experience, perspectives, age, genders and cultures leads to improved leadership, stronger decision-making and better outcomes for patients.' However, it also noted that RANZCOG had the highest percentage of female members in comparison to other Australian and New Zealand medical colleges, yet one of the lowest percentages of women in top-level leadership.

The GEDWG's first priority was to create and implement RANZCOG's Gender Equity and Diversity Action Plan. The first phase of the plan focused on improving gender equity within RANZCOG leadership and across the College, using prescribed targets. I'm happy to report that the targets have been met and that there has been a great deal of progress over the past four years in the gender composition of many parts of the College. In 2022, close to 60% of Fellows, 85% of trainees and 65% of Diplomates are female. In a majority of College committees there are majorities of women, reflecting the composition of the Fellowship. So the glass ceiling has been cracked, but not yet broken. We still need to see more women presidents – a succession of them over the next few years; we should not be accepting tokenism any more in this respect. We should see that the Board continues with a gender composition that reflects that of the membership as a whole.

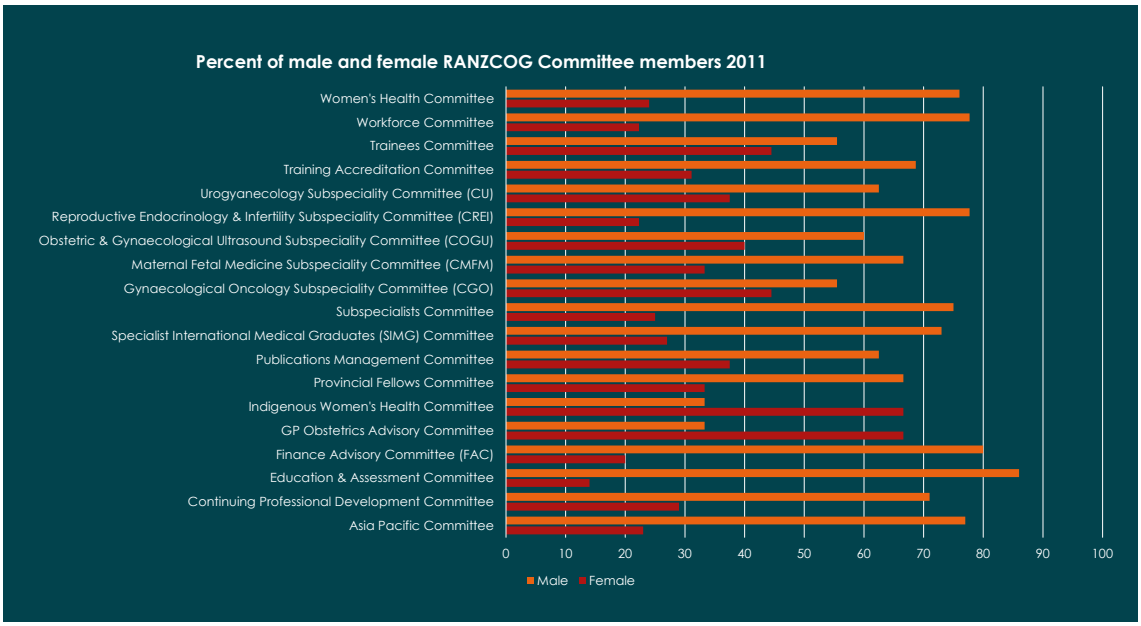


Figure 1 – Percent of male and female RANZCOG committee members 2011

RANZCOG Indigenous members

- 134 Members identify as Indigenous
- 32 Fellows and 1 Retired Fellow identify as Indigenous:
  - 7 Aboriginal Australian
  - 1 Torres Strait Islander
  - 11 Pacific Islander
  - 14 Māori

(Identifying ethnicity/ancestry is optional)

Figure 2 – RANZCOG Indigenous members

The Group's second aim has been toward ethnic diversity. Australia is now an extremely ethnically diverse society and this is reflected right now in you, my audience today. However, the percentages of First Nations trainees and Fellows in Australia and Aotearoa New Zealand are less than the percentages of First Nations people in both Australia and Aotearoa, which are 3.3% and 16.5% respectively; (Figure 2) this needs more positive action on the part of the College and is currently a consideration for the working group.

More also needs to be done in regard to minority ethnic groups and cultures, overseas trained specialist groups, and the LGBTQIA+ community. The aim of the working group is to gain representation that reflects current membership, within leadership and in other College roles, and to address the particular needs of minority groups.

At the same time, the decline in the number of male applicants for training posts and the intake of males into Fellowship training has been a concern of the working group. I have chaired a sub-committee that has studied the reasons for the decrease, with a

Gender composition of applications for RANZCOG Fellowship training in 2021

- 238 applicants – 189 female (79.6%), 48 male (20.2%), one non-binary
- Offers for training posts: 97 female (82.2%), 21 male (17.6%), one non-binary

Figure 3 – Gender composition of applicants

view to making recommendations to the RANZCOG Board, as we do not wish to see one group of young medical practitioners being completely excluded from training and practising O&G.

You can see here that male junior doctors applying for Fellowship training posts are not disadvantaged in comparison to female – the same percentages of applicants are successful in both groups. But the actual numbers of male applicants versus female have now been much smaller for nearly ten years.

My research group found that it is the experience of male medical students that most determines whether they might consider O&G as a career choice. We conducted quantitative and qualitative studies with medical students, and with junior doctors, and found that both groups felt that their experiences as students, particularly in birth suite, often led men to decide that they would not be successful in getting into training or be welcomed there. This is unfortunate, the career path should be open to all regardless of gender, and this is something the College's group is now working on. I would not like to see the College become an almost entirely female organization, unrepresentative of the general population. I remember when it was an almost entirely male organisation, and it was an uncomfortable place for women. I believe we need to consciously ensure that male applicants for training, both as Fellows and as Diplomates, are welcome, and this includes looking carefully at how to prevent bias, whether conscious or unconscious, in the selection process for training. A decision has been made to introduce quotas including 40% of males for Council and the Board; should we also be looking at a similar quota for trainee entry?

When Arthur Wilson did his specialist training it took about a year and there were no exams. When I trained in the 1970s there were six years of medical school and three years of MRCOG training. Now it takes up to eight years to graduate as a doctor, followed by internship. Admission to the training program brings another six years of rotations through a number of different urban and rural hospitals, the many demands of the core training assessment and major exams. Subspecialty training takes even longer.

The years when a woman or pregnancy-capable trainee is undertaking all this are almost always their twenties and early thirties, exactly the time in which, as obstetricians, we would advise a person who wishes to have children that they should try to do so. This dichotomy has been recognised by the College. Over the past thirty years there has been very vigorous discussion within the College around the topic – but we certainly gained job-sharing, very early, in 1985, and it was introduced through the efforts of the woman I've already mentioned, Ann Hosking, the first woman member of the College Council. Many trainees now have been able to take maternity leave and return into recognised posts in the training scheme, and some have taken paternity leave. Once training is completed there is also a growing tendency in private obstetrics to group practice, by both women and men, and as someone who spent seventeen years in solo private obstetric practice in Sydney, I think this is an essential and very welcome development, and one well-received by the majority of women, and indeed men. There are also now very many more staff specialist jobs which may be part- or full-time, in which women can practise our specialty while also having a family. On the other

Heather Munro, the first and only woman president of RACOG, elected in 1994.

Chris Tippett, first woman president of the merged RANZCOG, elected in 2006.

hand, it's also essential that trainees of all genders get adequate clinical experience during their training years and continue to maintain their skills as they practise, whether that's full or part-time; it's essential to be completely professional.

Over the 41 years I have been a Fellow I have seen enormous growth and evolution of the College. From time to time I have considered the question of whether we actually need a College, sometimes in discussion with colleagues, sometimes on my own. I always come up with the answer that yes, we do – despite occasionally being annoyed or depressed or infuriated by some decision or action of some part of the College. The educational, assessment, accreditation, research and advocacy roles of our College are all essential to our individual abilities to continue as specialist obstetricians and gynaecologists. At the heart of the College structure is the apprenticeship model of learning that is essential for professions that depend on the skills of both the hands and the brain. We can only learn from our elders who are already experts in the areas we aspire to. I do not think the unique role of medical colleges could be bettered by a university system, and certainly not by a governmental one. But the structure of the College requires the voluntary participation of active Fellows and trainees and Diplomates, because it's the practitioners who have the know-how about what obstetrics and gynaecology actually is.

There is a tendency for trainees and new Fellows to be a bit in awe of 'the College' and it's not unknown for established Fellows to be critical or dismissive. 'The College' sometimes is seen as an anonymous and uncaring building somewhere down in Melbourne. In fact, 'the College' is you, its members; you control it and the more involved you become the more it will reflect who you are. So I strongly recommend to trainees and recent Fellows – put up your hand and join in College activities. The more who do so, the stronger our College will be.

Arthur Wilson, were he here today, would be amazed by what the College has become, in terms of its membership, its many functions, and its contribution to reproductive healthcare in Australia and New Zealand. But I also think he would be impressed.

Thank you.

Building oncological skills in Taiwan

Aided by a grant under the Brown Craig Travel Fellowship, Dr Alexander "Alex" Chen was able to enhance his surgical and professional skills through a year spent working and learning in a Taiwanese hospital.

Alex currently practices obstetrics and gynaecology in Western Sydney, with public appointments at Westmead and Auburn Hospitals and private appointments at Westmead and Norwest Private, having previously worked in Victoria, Tasmania, and NSW. A fluent Mandarin speaker, Alex had long been interested in the possibility of working overseas and learning about a different healthcare system, while also enhancing his O&G skills. The opportunity came to fruition in January 2021, when he was awarded a Brown Craig Travel Fellowship grant from the RANZCOG Women's Health Foundation.

Established 1964, the Brown Craig Fellowship provides funding for recipients to visit any country outside Australia or New Zealand to study a scientific, research or clinical subject relating to the practice of O&G. The award of a $5,000 grant helped cover Alex's travel, accommodation and general living costs as he spent a year working at China Medical University Hospital in Taichung City, Taiwan.

"My year in Taiwan was an incredibly rewarding experience in regards to my broader professional development and in terms of my intensive surgical exposure in gynaecological oncology, urogynaecology, benign gynaecology and endometriosis surgery," says Alex. "I am deeply grateful to have received the Brown Craig Travel Fellowship, which helped make this placement possible."

The primary aim for Alex was to improve his surgical skills through intensive exposure to open, laparoscopic and vaginal techniques, under the mentorship of well-respected gynaecological oncology and urogynaecological surgeons. Alex also wanted to develop his knowledge of complex surgical pelvic anatomy through open and laparoscopic oncological surgery with pelvic lymph node and para-aortic lymph node dissection, and to apply this knowledge to benign gynaecological surgeries such as for deep infiltrating endometriosis.

Finally, during his time in Taiwan, Alex was keen to observe and be immersed in a different medical training environment. He hoped to learn about the regional and cultural variations in surgical training, and determine whether various aspects can be incorporated into Australian medical training.

Alex worked closely with Dr William "Wu-Chou" Lin and Dr Lian-Shung Yeh, two pioneers of laparoscopic surgery in Taiwan, who are respectively Head of Unit and Director of Gynaecological Oncology at China Medical University Hospital. In the early 1990s Dr Lin and Dr Yeh developed skills and techniques that were quite distinct from those that were emerging in other countries in the early days of advanced laparoscopy.

Dr Chen with surgical colleagues at China Medical University Hospital.

"A developed and vibrant democratic economy": Taichung City at night

"Learning from my two mentors was an incredibly rewarding experience," recalls Alex. "Dr Lin and Dr Yeh are gynaecological oncologists who not only perform oncological surgery, but also perform complex benign surgeries including deep infiltrating endometriosis using oncological techniques. Skills sometimes difficult to obtain in Australia and extremely beneficial to my practice were attained from my overseas fellowship."

Alex's Taiwanese colleagues were friendly, welcoming and supportive in helping him navigate the challenges of practicing in a different public health system, in a different societal and cultural setting, while working predominantly in Mandarin. Despite similarities to the Australian healthcare context in terms of patient expectations, daily hospital operation and resource limitations, there were also notable differences.

"Taiwan is a developed and vibrant democratic economy," says Alex. "Its public health system has evolved to be very cost-efficient, and access to specialist healthcare is incredibly convenient. Sometimes in as little as one day, patients can self-refer to a specialist and have investigations performed with a surgery date organised within a week.

"However, as a specialist-based system which developed independent of general practice, its highly specialised silos of care can lead to patient confusion on which specialty to see, due to the absence of initial generalists who can diagnose and refer appropriately. This can lead to inefficiencies in healthcare spending, through multiple presentations of patients to different hospitals, and often repeated investigations."

Along with the challenges of a different healthcare system, Alex also had to adapt to the social and cultural differences of working in Taiwan. Realising what was important to patients in Taiwan meant Alex had to modify his practice to accommodate their wishes.

He explains: "An example of this is the strong cultural focus of Taiwanese women wishing to retain their uteruses, even when future pregnancies were not a consideration, leading to many patients desiring to undergo myomectomies and removal of 10-20 fibroids, rather than a hysterectomy."

Alex's year in Taiwan has brought various benefits. He gained extensive technical experience and a deeper understanding in areas such as: pelvic side wall dissection, including ureterolysis; dissection of the pelvic vasculature, including the external and internal iliac vessels and relevant branches; and pelvic and para-aortic anatomy. Alex also acquired a greater familiarity with advanced open, laparoscopic, vaginal and robotic techniques.

Chinese Medical University Hospital, Taichung City.

"Through this fellowship I am now much more comfortable with general pelvic side wall dissection in laparoscopic and open surgery," says Alex. "And I have had exposure to a variety of different operative techniques and skills which I had not encountered in Australia. Though the operations are the same, the approach and operative techniques can be considerably different. I believe I can now bring some of these tips, tricks and techniques to Australian trainees."

More broadly, complete immersion in practicing medicine in a different cultural and societal context has brought substantial benefits for Alex in his general professional approach. He is now keen to apply what he learnt to his work in Australia.

Alex concludes: "My year in Taiwan has not only taught me advanced surgical skills and techniques, it has also taught me to be more receptive and responsive to sociocultural issues, leading to a greater understanding of challenges and barriers in other healthcare systems. Learning how to interact with colleagues using a different language within a different culture has also been a fantastic learning opportunity. This experience has helped me become a more culturally sensitive obstetrician and gynaecologist and further developed skills which I hope will benefit Australian women in the future."

To find out more about the Brown Craig Travel Fellowship and to apply, scan below:

To view all the funding opportunities available to RANZCOG trainees and members, scan below:

Building networks and enjoying local cuisine – both invaluable benefits of a travel Fellowship!

RANZCOG Women's Health Foundation

Despina Demertzidis
Scholarships and Grants Coordinator
RANZCOG

The RANZCOG Women's Health Foundation supports philanthropic initiatives in the areas of First Nations and Māori women's health, global women's health, and women's health research. We apply our knowledge and expertise to best align programs and awards with each of the Foundation's focus areas. These include the development of medical, midwifery and research skills in the reproductive health workforce in the Pacific, and women's health research through the award of research grants leading to significant outcomes in women's health. Through the generous support of trustees and donors, we have been able to create a strong support network for research and community work within our membership.

Global health in the Pacific

The RANZCOG Women's Health Foundation aims to assist in building O&G workforce capacity in Pacific Island countries via support for training, education and research. Pacific O&G clinicians receive access to RANZCOG resources, such as publications and online learning modules, as well as scholarships to attend RANZCOG Scientific Meetings in Australia and Aotearoa New Zealand. RANZCOG also supports and collaborates with the Pacific Society for Reproductive Health (PSRH), an Auckland-based non-government organisation focused on the education of the Pacific reproductive health workforce.

The support of the RANZCOG Women's Health Foundation is critical to these global health activities. In 2022, the Foundation offered three Pacific scholarships to O&G clinicians from Papua New Guinea and Tonga to attend RANZCOG Scientific Meetings in Darwin and on the Gold Coast. Attending these events affords recipients an opportunity to update their O&G knowledge and skills, learn more about new products, techniques and technologies, and network with O&G colleagues.

The Foundation also provides funding for the PSRH to maintain a secretariat for the purpose of enabling its work. This includes organisation of a biennial conference held in the Pacific, the only one of its kind focused on Pacific women's health. The first PSRH Conference in three years was held in Samoa in August 2022, bringing together Pacific doctors, midwives, nurses and others with an interest in Pacific women's health for several days of professional development, connection and collaboration.

Through these initiatives and projects, the Foundation assists in the establishment of a strong community of qualified healthcare professionals who contribute towards improving health outcomes for women and their families in the Pacific.

Research in women's health

The RANZCOG Women's Health Foundation proudly supports Fellows, trainees and scientists pursuing high quality, innovative research and training in women's health. It is through the generous bequests, donations and contributions of our invaluable partners that the Foundation is able to continuously support and empower individuals on their professional and academic journies in women's health. Research scholarships, Fellowships and travel grants are awarded annually across Australia and Aotearoa New Zealand, to promising researchers committed to continuous improvement in the fields of obstetrics, gynaecology, and the reproductive sciences. The Foundation strives to recognise researchers at different stages of their careers, in particular young researchers, to assist them as they progress their careers. We support doctors pursuing international research opportunities in the world's leading hospitals and institutions, as well as in low-resource settings in developing countries. Research has been undertaken in a broad range of areas such as endometriosis, menopause, fetal growth and development and innovative surgical techniques. It is this incredible work that leads to significant outcomes in women's health. The Foundation has awarded fifty (50) research and travel grants in the past five years, valued in excess of AU$1.2million.

Supporting current and emerging research is crucial in the continuous improvement of health services and outcomes for women and their families. It also enables our members to keep up to date with the latest developments in the O&G space. The travel grants have been imperative in providing our members and trainees with opportunities to work and live in health settings that are very different to our own, and it has enriched their experience and perspective in service delivery. We are proud to play a part in contributing to improvements in health services and delivery for women and their families.

You can read about the work of some of our recipients in this issue. To find out more about our global health work and research awards please visit **ranzcog.edu.au/our-college/our-work/womens-health-foundation**.

Community, crime and creativity

Lauren Donley
Publications & Media team
RANZCOG

For most of our readers, Professor Caroline de Costa probably requires little introduction. Australia's first female Professor of Obstetrics and Gynaecology. Women's health trailblazer. Mother of seven. Prolific non-fiction and crime-fiction author. These are just a few titles (or perhaps we should say, 'aliases') that spring to mind.

When *O&G Magazine* last caught up with Professor de Costa (Vol.23 No 4, Summer 2021), during the height of the COVID-19 pandemic, she had just published an autobiographical book, *The Women's Doc*, and was hoping to take it on tour. Among other non-literary commitments, she was also contemplating the next book in her *Cass Diamond* crime-fiction series.

In keeping with the theme of 'community', we chatted with Professor de Costa one year on about her committee involvement, teaching activities and creative writing process.

Paying it forward

Since stepping away from clinical practice in 2016, Professor de Costa has continued to share her expertise with the College, and the wider O&G community. She currently sits on a number of RANZCOG committees, including:

- Gender Equity and Diversity Working Group
- Historical Collections Committee
- Sexual and Reproductive Health Special Interest Group
- Women's Health Committee

And while she now calls Melbourne home, Professor de Costa also remains keenly invested in shaping the next generation of O&G professionals as a teacher and supervisor at James Cook University in Cairns – a role that she notes presented numerous challenges during the recent move to online learning, particularly given the "very three-dimensional nature of pregnancy and birthing."

At the other end of the spectrum, Professor de Costa points to the achievements of two of her students – a PhD and an honours candidate – who completed and submitted their research projects for assessment in 2022. Both overcame considerable obstacles and last-minute adjustments to research methods along the way.

One of these projects was conducted in conjunction with the RANZCOG Gender Equity and Diversity Working Group, and involved two FRANZCOG trainees, Dr Helena Obermair and Dr Hon Chuen Cheng. The study explored perceptions of gender discrepancies among medical students and junior doctors in O&G (see Box 1).

Today, more than 80% of applicants accepted into the FRANZCOG training program are female. Back in 1974 when Professor de Costa first applied to become an O&G registrar in Sydney, this number was zero.

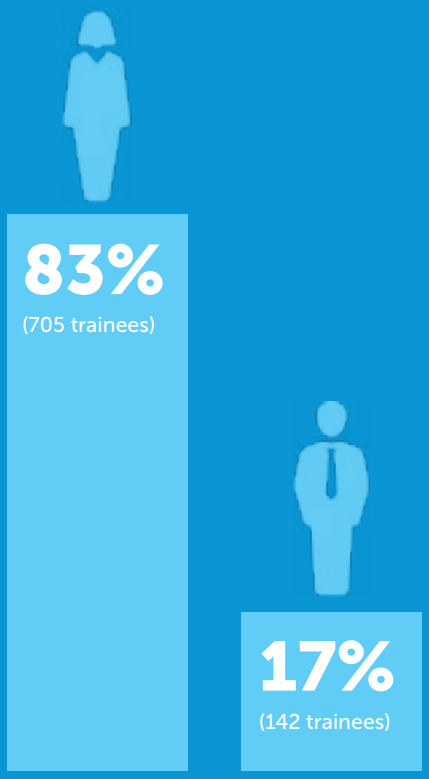
As someone who helped to pave the way for this remarkable change, Professor de Costa remains a strong advocate for gender parity within O&G leadership roles. However, she also firmly believes that everyone should feel equally welcome within the field, regardless of gender.

Medical and creative licenses

For those who have dabbled in academic writing, a transition to crime fiction might seem like quite a leap. But for Professor de Costa, it was somewhat of a natural progression. She recalls a particular experience writing fictionalised patient case studies with a long-time friend from medical school in Ireland. The content was not only well-received, but also enjoyable to write, and it planted a creative seed.

These days Professor de Costa carves out time to write around a busy work, travel and social schedule, which means that her creative process tends to ebb and flow. "Inspiration can come in unexpected places, like the supermarket," she says. "It will stimulate a period of writing and may also trigger adjustments to existing details of the story." So, the plot, and the ending, are subject to change.

One aspect that Professor de Costa does have locked down though is a trusted network of reviewers and sense-checkers. For example, one friend who works in the Criminal Investigation Branch (CIB) helps to ensure that her descriptions of police matters are accurate and realistic, from search warrants, right down to the make and model of police vehicles. And of course, she has most of the murderous medical details covered.



Female and male FRANZCOG trainees in 2022

What's driving gender discrepancies during early stages of O&G training?

Perhaps unsurprisingly, a recent paper by Dr Monyi Win Kyaw, Professor De Costa and others, indicated that both positive and negative experiences during O&G rotations strongly influence decisions to pursue a career in O&G, and that these views are reinforced in the junior doctor years.[1]

The study also highlighted a need within the specialty to:

- Incorporate women's reproductive health into the medical curriculum at an earlier stage (e.g. with general practice or rural placements in the preclinical years)
- Support all medical students, regardless of gender, to develop strong and respectful relationships, particularly with consultant obstetricians, midwives and midwifery tutors
- Better understand the barriers facing male students at all career stages, including at selection into the FRANZCOG training program
- Educate patients at teaching hospitals and clinics to help them understand and accept the presence of medical students at reproductive consultations and procedures

Box 1. Findings from Professor de Costa's study with the RANZCOG Gender Equity and Diversity Working Group

Write what you know

To date, there are four books in the Cass Diamond series: *Double Madness* (2015), *Missing Pieces* (2018), *Blood Sisters* (2019), and a prequel titled *Hidden Lives* (2021). All are set in Far North Queensland, a region that Professor de Costa knows well, having spent 15 years working at Cairns Hospital and travelling to remote outreach clinics on the Cape York Peninsula. Against this steamy tropical backdrop, Cass Diamond unravels mysteries intertwined with themes such as psycho-sexual depravity, race and ethnicity, sex-trafficking and abortion.

Similarly, Detective Cass Diamond – the Indigenous female protagonist – is born out of clinical and personal experience. "I thought long and hard about writing from the perspective of an Aboriginal woman," she says. "But the character is based on the many strong, smart, talented women I've met, and it's an important narrative."

In the early 1990s, prior to her move north to Cairns, Professor de Costa also established the first specialist obstetric, gynaecology and women's health clinic at the Aboriginal Medical Service in Redfern, Sydney.

Crime never sleeps

So, what's next for Professor de Costa? After a false start due to the pandemic, she is currently travelling abroad to promote *The Women's Doc* in Ireland, where she says the book has done "unexpectedly well." Although perhaps this shouldn't come as such a surprise given that Professor de Costa built her early career and reputation as a women's health trailblazer in Dublin in the 1960s and 70s.

From Ireland, Professor de Costa is heading to Canada to spend time with her son, and a Palestinian refugee family who she first met in Cairns through her work supporting refugee and asylum-seeker women for over three decades. Both families know her as grandmother to their children.

And as for Detective Cass Diamond? Professor de Costa's fifth book is nearing completion. A few more trips to the supermarket for inspiration might just do the trick... so watch this space!

Reference

1. 1. Win Kyaw M, et al. Aust N Z J Obstet Gynaecol. 2022 Nov 5. doi: 10.1111/ajo.13617. Online ahead of print.

Q&A

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

Prof Deborah Bateson

A/Prof Marion Saville

Prof Megan Smith

Q How do I support my patients in self-collection for the National Cervical Screening Program?

A On 1 July 2022, a major policy change supporting the informed choice of either self-collection of a vaginal swab or a clinician-collected cervical sample for primary human papillomavirus (HPV) screening was implemented within the National Cervical Screening Program (NCSP). This change, grounded in improving access and equity, was announced on 8 November 2021 by then Minister for Health and Aged Care, Greg Hunt, following recommendations from the Medical Services Advisory Committee (MSAC) after detailed review of the evidence around the accuracy and acceptability of self-collection.[1]

The shift in 2017 from 2-yearly Pap tests to 5-yearly HPV testing in the NCSP, and the national school-based HPV vaccination program for 12- to 13- year-old girls and later boys, have put Australia on track to be the first country in the world to reach the World Health Organisation (WHO) cervical cancer elimination target of fewer than 4 cases per 100,000 women as early as 2028 to 2035.[2,3] However, while cervical cancer was the 14th most common cancer in females in 2020 there were still approximately 743 new diagnoses in 2017 and 179 deaths in 2019 in women between 25 and 74 years of age, with almost three-quarters of deaths occurring amongst those who are under or never-screened.[4]

At the end of 2020 more than 30% of those eligible for screening were overdue[5], with the limited available data highlighting that under and unscreened people belong to multiple and varied groups including:

- Aboriginal and Torres Strait Islander women who have an almost four-times greater chance of dying from cervical cancer than non-Aboriginal women
- Culturally and linguistically diverse (CALD) women including new migrants and refugees
- Patients with physical and/or intellectual disability
- Members of the LGBTQI+ community including transgender men
- Those with a history of sexual assault and/or who feel stigma and shame around intimate examinations
- People who experience pelvic pain including vaginismus with a speculum examination
- Patients with previous negative screening experiences

Universal self-collection is a potential gamechanger in overcoming some of the screening barriers faced by these groups, and to make the elimination goal a reality for all.

In this article we present the evidence for self-collection, review the eligibility criteria within the NCSP and provide an overview of the updated guidelines for the management of screen-detected abnormalities in the NCSP (the Guidelines) for self-collection. O&Gs and midwives are well placed to opportunistically offer the choice of self-collected or clinician-collected HPV sampling to under and unscreened patients, as well as to patients requiring a HPV-only test, and not a co-test, anywhere in the NCSP pathway.

Accuracy of and eligibility for self-collection

Prior to the implementation of the renewed NCSP, current evidence suggested that HPV testing of self-collected vaginal samples using available signal amplification tests was slightly less sensitive than HPV testing of clinician-collected cervical samples for the detection of cervical intraepithelial neoplasia (CIN)2+.[6] However, an updated meta-analysis showed equivalent accuracy of self- versus clinician-collected samples when using today's polymerase chain reaction (PCR) tests.[7] Based on the earlier evidence, self-collection in the renewed NCSP was initially restricted to those who were under-screened (aged 30 years or more and 2 or more years overdue for screening), and uptake was extremely low (< 1% of those eligible[8]) due to a combination of lack of confidence in self-collection by clinicians, a limited number of laboratories offering processing and low awareness by clinicians and patients.[9] The removal of restrictions to self-collection since 1 July 2022 is likely to see an increase in demand for self-collection, including by under-screened groups.

Self-collected vaginal samples are tested for oncogenic HPV with partial genotyping into either HPV (16 and/or 18) or one or more of the other 12 oncogenic HPV (not 16/18) types. As a self-collected sample does not collect cells from the cervix, it cannot be used for cytology, which precludes self-collection for anyone requiring a co-test. However, anyone eligible for a CST, or a HPV test alone, can be offered the choice of either a self-collected or clinician-collected sample for HPV testing. As noted, this includes antenatal patients for whom this visit

Figure 1. Simple self-collection instructions

may be the first time they have come in to contact with a health service and be offered screening.

Supporting informed decision-making

In order to support informed decision-making, patients must be given information about how a self-collected vaginal sample and a clinician-collected cervical sample are performed, as well as the pros and cons of each, including the need to return for a clinician-collected cytology test for most of those in whom HPV (not 16/18) is detected. Step-by-step guidance about self-collection is available from the NCSP (Figure 1) in 17 languages including six Aboriginal and Torres Strait Islander languages, and by instructional videos.[10]

While previously only three pathology labs were offering processing of self-collected samples, there are now a range of HPV assays with TGA-approved claims for self-collection, and several labs now offer this service with more expected to follow. Some labs use red-topped dry flocked swabs which are sent to the lab directly for processing, whilst others use the Roche platform which requires the practitioner to agitate the dry swab collected by the patient in a liquid medium which is then sent to the lab for processing. Practitioners are encouraged to contact their local pathology service to confirm that they can process self-collected vaginal samples, or that they have an arrangement in place to send them on to another lab for processing, and to ensure they have the correct swabs, handling requirements and resources to support their patients.

Labelling the sample as self-collected and providing this information on the pathology request form is essential to ensure the lab performs the correct test and provides the correct clinical recommendations. In addition, the pathology request form should be completed with appropriate clinical and patient identification information. This includes asking and documenting whether patients identify as Aboriginal and/or Torres Strait Islander as this impacts on clinical management in the intermediate risk pathway.

Additionally, the National Cervical Screening Register (NCSR) supports the screening program by sending invitations and reminder letters to participants and has updated information on its Provider and Participant Portals on the option of self-collection. The NSCR Provider Portal,[11] accessible to all registered practitioners via their PRODA account, is extremely useful as it allows point of care access to the patient's screening and treatment history.

Where can self-collection occur

Universal self-collection has been introduced with the aim of bringing under and never-screened people into the NCSP. The Guidelines,[12] while stating that self-collection is preferable in a health care setting as this guarantees timely return of the sample, also support clinicians in providing screening in any setting they believe is appropriate to encourage participation of an individual who may otherwise remain unscreened. This opens up the possibility of supporting screening via telehealth, through community outreach or even screening at home, although critically the requesting clinician takes complete responsibility for informing patients of their results and any required follow-up.

Self-collection clinical pathways within the NCSP

The clinical pathways within the NCSP are based on classification of CST results into low, intermediate or higher risk categories. In the vast majority (> 90%) of patients, HPV will not be detected and they can be advised to have a repeat screen in 5 years due to the test's high negative predictive value.[13] Patients in whom oncogenic HPV (not 16/18) is detected are generally advised to return as soon as is practical for a clinician-collected cytology triage test in order to determine their risk category and next steps along the pathway. This is expected in around 6% overall of patients undertaking routine screening with highest rates in 25- to 29-year-old women (up to 17%) and lowest in those aged 50 and older (approximately 3%).[14] Patients in whom HPV (16/18) is detected, expected in around 2% of routine screeners, are referred directly to colposcopy. In the updated Guidelines, cytology is recommended at the time of colposcopy.

Unsatisfactory HPV results are very rare (around 0.2% for clinician-collected tests and 2% for self-collected tests) and all approved assays in Australia have a cellularity control which negates concerns that an empty or inadequate sample could lead to a negative HPV test result. However, while the presence of blood in the sample is generally not of concern, there is a chance that inhibition of the PCR can sometimes occur in the presence of a large amount of blood. Where possible patients can be advised to take their self-collected screening sample between menstrual periods, but screening should not be deferred if the patient is unlikely to return, and all approved assays in Australia have a control to detect assay inhibition.

Additionally, the updated Guidelines support clinicians in providing assistance to patients if they have difficulty in taking their vaginal sample, or for the clinician to collect the vaginal sample using a self-collection swab without a speculum if this is the patient's preference. This is still classified as self-collection on pathology request form and may be useful for, for instance, patients with lack of mobility or a movement disorder.

Self-collection at any time an HPV-only test is recommended

Self-collection of a vaginal sample can also be offered as an alternative to a clinician-collected cervical sample at any time in the pathway where an HPV-only test is recommended (see Box 1). Where HPV is not detected, patients can be discharged to routine screening in 5-years, and where any HPV is detected then the patient is either advised to return for a follow-up clinician-collected cervical sample for cytology triage or referred directly to colposcopy, depending on the circumstances.

HPV-only test: non-screening contexts where self-collection can be offered

- HPV follow-up tests after an intermediate risk screening result at 12 and 24 months
- HPV test between 20 and 24 years and 9 months of age (a single HPV test could be considered on an individual basis for patients who have had sexual contact prior to age 14 and prior to HPV vaccination, but is not required)
- HPV test following either a normal or Type 3 TZ colposcopy and cytology result of negative, pLSIL or LSIL
- HPV test following total hysterectomy with no evidence of cervical pathology but an unknown screening history

Box 1. Examples of situations where self-collection can be offered

Prior to 1 November 1 2022 for a non-screening HPV test, a medicare rebate for self collection is only available for patients whose index CST was also self-collected. Patients could choose to have a non-rebateable test and/or the clinician can discuss the fees with their pathology provider.

Table 1 Comparison of clinician collected and self-collected samples for cervical screening

	Clinician-collected cervical sample	Self-collected vaginal sample
Is it accurate?	Both methods have equivalent sensitivity for the detection of HPV and CIN2+/AIS[1,2]	
Identifies HPV infection?	Yes	Yes
Is liquid-based cytology (LBC) and co-testing possible?	Yes	No
Indicated for • Those who are eligible and due or overdue for cervical screening, including during pregnancy • Other points in the pathway where only an HPV test is required	Yes	Yes
• Patients who have postcoital or intermenstrual bleeding, post-menopausal bleeding, or unexplained persistent unusual vaginal discharge[3] • Those undergoing Test of Cure surveillance or have been treated for adenocarcinoma-in-situ • Patients who have had a total hysterectomy with history of high-grade squamous intraepithelial lesion • Patients who were exposed to diethylstilbesterol in utero	Yes	No
Management of participants in whom HPV is not detected >80%	Return in 5 years	Return in 5 years
Management of participants in whom HPV (not 16/18) is detected ~6%	Reflex LBC performed on original sample, no need to return for a further sample to be taken	Return for clinician-collected cervical sample for LBC. The incidence of HPV (not 16/18) is highly age dependent. NCSR data[4] 25-29 years 17% · 50-54 years 4% 30-34 years 10% · 55-59 years 3% 35-39 years 6% · 60-64 years 3% 40-44 years 5% · 65-69 years 3% 45-49 years 4% Patients aged 70 to 74 with HPV (not 16/18) detected are referred to colposcopy
Management of participants in whom HPV (16/18) is detected ~2%	Refer for colposcopy	Refer for colposcopy
Management of Unsatisfactory HPV test	Repeat in 6-12 weeks	Repeat at earliest convenience

[1] Arbyn et al. Detecting cervical precancer and reaching underscreened women by using HPV testing on self samples: updated meta-analyses. BMJ 2018; 363: k4823
[2] Saville et al. Analytical performance of HPV assays on vaginal self-collected vs practitioner-collected cervical samples: the ScreenPE study. Journal of Clinical Virology (2020); doi: https://doi.org/10.1016/j.jcv.2020.104375
[3] Co-testing is not required for breakthrough or irregular bleeding due to hormonal contraception or a sexually transmitted infection, heavy menstrual bleeding, or contact bleeding at time of obtaining a routine cervical screening test sample
[4] Smith et al. BMJ 2022;376:e068582 Available at: https://www.bmj.com/content/376/bmj-2021-068582

Provision of additional support for patients choosing self-collection

The Guidelines recognise that unscreened and under-screened patients who access self-collection and in whom HPV is detected may require additional and individualised support to progress along the clinical pathway and to access follow-up services.

This can include reassurance and explanation with longer appointments and additional follow-up contact. At least initially, underscreened and unscreened patients who choose self-collection may have a higher risk of requiring referral to a colposcopy service and continuity of sensitive care is essential.

Conclusion

Self-collection offers additional choice and control for participants in the NCSP and is a potential game changer in overcoming inequities in cervical cancer incidence and mortality. O&Gs and midwives are well placed to offer self-collection to patients who are under or never screened, including antenatal patients for whom this may be the first opportunity to be offered screening. Offering self-collection can help ensure the WHO cervical cancer elimination targets can be reached equitably across Australia.

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BRIAN SPURRETT ORATION 2022

PSRH: a vision becomes a reality

Emeritus Prof Rajat Gyaneshwar
MBBS, MHEd, FRANZCOG

This is the full version of the Brian Spurrett Oration delivered at the Pacific Society for Reproductive Health (PSRH) 14th Biennial Conference held in Apia, Samoa from 30 August to 2 September 2022.

The President of PSRH, the members of the Executive Board, the President of RANZCOG, representatives of UNFPA and SPC, Drs Fidow and Ah Ching and the Local Organising Committee, friends and colleagues from across the Pacific. Indeed, PSRH has brought us together for the 14th time and yes, the vision has become a reality.

I am grateful for being invited to present this Oration and would like to thank the President of RANZCOG for his flattering words of introduction. The RANZCOG Women's Health Foundation supports the Brian Spurrett Oration. My sincere thanks for their support for this Oration.

This morning I want to share my thoughts on how Brian's vision has become a reality.

Brian Spurrett, like you and I, chose women's health for a career. He and his wife, Kerry, shared a passion for serving others, especially in women's health. Sadly, she has not been able to join us at this conference. I think she has attended the preceding 13 Biennial Conferences. We remember her fondly and wish her the very best Pacific greetings.

Brian succeeded because he had a vision. He shared his vision with others and lobbied for support amongst his RANZCOG colleagues. He convinced them that reaching out into the Pacific was a natural extension of RANZCOG's mission to provide quality health care for women.

Brian was a clinician, researcher, teacher and administrator. He was busy. But at the same time, he saw that collegiality was important. He became active in RANZCOG affairs first at a local level then at a state level, then at a national level and finally at the international level. He rose to the position of Senior Vice-President, and some of us would say should have become President. He was able to share his passion for working in developing countries with key collaborators in the College Council and thus began PSRH, which was the result of RANZCOG promoting professional networking in the Pacific at a small workshop in Suva in 1993. At the end of a very stimulating two days of clinical story telling and exchange of ideas, a working group of Pacific specialists was set up under the chairmanship of Wame Baravilala to form the predecessor of PSRH, called SPROGS, or South Pacific Regional O&G Society. The change in name in Apia in 1995 was in recognition of the new organisation's acknowledgement that PSRH must include all health professionals engaged in reproductive health, thus the Pacific Society for Reproductive Health.

I would like to share some thoughts on the values which drove Brian.

Not unreasonably, security is a strong consideration for all of us. Security requires enough money to cover our needs and recognition of our professional efforts. However, in addition there is our love, commitment and compassion. These are priceless components of fulfilment. In the end we all aspire for peace, contentment and inner joy.

Our individual needs are great, but these should not confine us to our small, self-centred selves. Selflessness frees us to express our generosity, compassion and love. Selflessness is best expressed in service. Brian was selfless. He cared for those around and beyond him, and served them.

Brian was happy and content, even though his life was sadly shortened just as he was at the very height of his already distinguished career. I visited him the night before his death. He was at peace. I asked him if there was any unfinished business. He said to me, "the Young Gynaecologist Program needs to be developed further" and we talked about professional networking being important in lifting the quality of women's health in the Pacific. PSRH is unique. It brings midwives and obstetricians together as equals. It values teamwork and team spirit. As for young gynaecologists, we will later at this conference be recognising Dr Nanise Sikiti, the first Pacific gynae-oncologist trained through a rigorous program designed by the International Society of Gynae Oncologists and supported by PSRH and its partners.

Prof Rajat Gyaneshwar delivering the Brian Spurrett Oration at the 2022 PSRH Conference in Samoa.

Nani was a Young Gynaecologist Awardee (YGA) of AOFOG. Her paper on cervical cancer received the best presentation award against stiff competition from YGAs from several other countries of the Asia-Pacific region. She then was funded by AOFOG to present at FIGO in Vancouver.

Brian died in the year 2000. He became ill soon after the Apia PSRH meeting in 1997 and could not attend the Suva PSRH meeting in 1999. This meeting also brings back some sad memories. Chris Kohlenberg, a member of the RANZCOG Council, was returning home after running a pre-conference workshop on ultrasound in Suva. He died in a plane crash between Suva and Nadi. At this conference we have had the advantage of 7 pre-conference workshops facilitated by professionals with international credentials.

Brian Spurrett and Chris Kohlenberg have made lasting contributions to women's health in the Pacific. We honour them and remember them with fondness. Our gratitude to them remains as strong today as it was when they were with us.

We should ask ourselves how we too can make a lasting contribution in our chosen profession in women's health. I would argue that we improve our chances of doing this through collegiality, partnerships and commitment to quality.

The Sustainable Development Goals (SDGs), which followed the Millennium Development Goals (MDGs), lays emphasis on Partnerships for the Goals in its 17th and last goal. Without partnership we limit our impact. Partnerships are all about having a shared vision, collaboration, sharing resources, building capacity and efficiencies. Alone we may not succeed but together we can move mountains. Our combined efforts are essential. To work together we need to talk together with an open heart and a shared vision. To work together we need to find ways to combine our strengths in tackling the challenges we face in delivering our vision.

This PSRH meeting has brought us all together and let us see how we can work together to address the most significant challenges our region faces in delivering quality women's health care. We are joined by RANZCOG, which is committed to quality care in women's health; by UNFPA who are the champions of sexual reproductive health (SRH); and by SPC with its long history in the Pacific development agenda. There are other partners such as Ministries of Health, the training institutions, IGCS, Counties Manukau, RACS, RCOG and others such as Liverpool and Nepean Hospitals in Sydney, and Middlemore Hospital in Auckland, who have all contributed to the PSRH agenda to mobilise professional networking to empower our Pacific SRH workforce.

At the first Brian Spurrett Oration in Madang in 2001, I spoke on safe motherhood. The emphasis then was to make every pregnancy safe. This of course will always remain vital in women's reproductive health.

Each of the seven pre-conference workshops this week is about improving the quality of care. Human reproduction is a key part of living. To enjoy our full human potential, we must be free from the burdens and complications associated with our reproductive function. We share the UNFPA vision of "delivering a world where every pregnancy is wanted, every

childbirth is safe and every young person's potential is fulfilled." Our focus should remain on this vision of choice and the full enjoyment of our sexuality without fear, and at the same time being empowered to avoid sickness and disease due to our reproductive function. However, on this occasion I wish to address an emerging challenge which could paralyse our efforts in improving women's health.

As I was preparing for this Oration, I came across a recent article by authors affiliated with the University of Technology Sydney (UTS) where the WHO Collaborating Centre for Nursing, Midwifery and Health Development is based. Two previous Brian Spurrett Orators, Professors Caroline Homer and Pat Brodie, were amongst the faculty responsible for the establishment of this Collaborating Centre. In their article entitled "Sustain and Retain Health Workforce", Buchan et al note that 1 in 5 physicians and even more nurses are resigning post-COVID. Between 2019–2021 there were 27.9 million nurses worldwide, with a shortfall of 5.9 million.

I do not have recent local human resource figures, but I fear our problem in the Pacific could be worse. In the small health centre near me in Fiji, 3 of our 4 nurses recently resigned to go to New Zealand as carers. Yesterday morning on our walk, we met some senior health officials here in Samoa. They noted that Samoa has a shortage of some 500 nurses.

A recent virtual 14th Pacific Health Ministers Conference hosted by Tuvalu and supported by SPC and WHO earlier this year noted:

- The heath workforce is strained
- The infrastructure is inadequate
- The health budget constrained
- The burden of non-communicable diseases (NCDs) is severe
- The health-seeking behaviour in the community is problematic.

Amongst several resolutions put forth by the Health Ministers, one was to consolidate resources and integrate services.

For those of us in reproductive, maternal, neonatal, child and adolescent health, we need to find ways in which we integrate our services with NCDs which are responsible for the biggest burden of disease in the Pacific. We do not have the resources to be siloed into our individual specialities. We need to focus on the individual patient's needs with an approach to wellness that extends from the womb to the tomb. Our focus must not be merely disease oriented. Empowering the community and the individual to avoid health risk-taking behaviour is essential, screening for at-risk individuals is good strategy, and providing targeted, quality care with best practice ensures we protect our patients from undue complications caused by poor care.

The NCD burden is huge on SRH, and vice versa. For example, fetal growth restriction is associated with subsequent insulin resistance. Obesity, diabetes and hypertension have huge impact on reproduction and reproductive organ disease.

I would now like to move onto the issue of sustaining and retaining our health workforce. However, to address the issue of dissatisfaction amongst our health care colleagues we need to address the issue of a happier workplace which is free from bullying and harassment, and where there is transparency in HR processes. RANZCOG and RACS have recently addressed some of these issues. PSRH may consider similar initiatives in the Pacific. The Clinical Quality Improvement Program identified by the 14th Pacific Ministers of Health could build into it staff support strategies including efforts to 'Care for the Carer'.

It probably is important to note that after the first Pacific Health Ministers meeting in Fiji in 1995, the Yanuca Healthy Islands Declaration was made. As a consequence, DFAT commissioned RACS and

2022 PSRH Conference delegates and special guests

Professor Gordon Clunie to develop a medical postgraduate program at the Fiji School of Medicine. Wame Baravilala was the Dean when the Masters program began. Many of you present here are beneficiaries of this program.

And finally on this issue, SPC has hosted the DFAT Pacific Clinical Services Program since 2017. One component of the program is to support Pacific clinical organisations such as PSRH. Here is an opportunity for the PSRH Board, SPC and RANZCOG to collaborate on sustaining and retaining the health workforce. SPC supported the South Pacific Chiefs of Nursing and Midwifery virtual meeting in 2021. The UTS WHO Collaborating Centre would be a key partner.

I want to move onto the partnership between PSRH, RANZCOG and UNFPA. In 1993, 25 of us met in Suva in a meeting organised by RANZCOG and funded by DFAT. At the conclusion of the meeting, Wame Baravilala was appointed as the Chair of the Steering Committee to form PSRH's predecessor, SPROGS. UNFPA was persuaded to fund the first secretariat for this organisation. This relationship has continued over the years, but perhaps needs to be revisited to customise it to the current needs.

That vision of 1991, and careful strategic thinking and commitment, has led PSRH to bring us all together for this 14th Biennial meeting. What an amazing achievement, that all of us can be proud of. In the last three decades, RANZCOG has awarded Associate Membership to 65 Pacific Specialists in O&G. This recognition has been a morale booster for our colleagues.

The vision of PSRH was also to empower midwives and nurses as equal partners in reproductive health. Overall, 107 Brian Spurrett Fellowships and Pacific Midwifery Program Fellowships have been awarded. RACS, in collaboration with RANZCOG and PSRH, has conducted several in-country professional development workshops on intrapartum care and clinical decision making. RANZCOG has provided faculty support to FNU and UPNG to strengthen their undergraduate and postgraduate programs in O&G. Training programs have been developed in managing emergencies in obstetrics, in ultrasound scanning, and in coloscopy. Fellowships have been granted for postgraduate trainees to attend pre-exam courses, and several scholarships have been awarded to attend the Anatomy of Complications Workshops. PSRH has encouraged and made it possible for several of us to travel and network with each other since its inception in 1993.

I want to move onto the Pacific Midwifery Leadership Program. I would like to acknowledge Carmel Walker for this program. This is a 7-week program especially designed for the Pacific midwife or nurse for their professional development, including leadership skills, improving clinical practice, improving clinical supervision, and role modelling professionalism and respectful maternity care. Professor Caroline Homer has been a significant contributor in the development of research skills amongst the midwives.

In 2017 at the Vila PSRH meeting, Carmel Walker and then-President of PSRH, Kathy Gapirongo, a midwife from the Solomons, reported that 71% of the program participants had achieved promotion to higher roles; their job satisfaction had improved, as had their leadership skills and clinical practice.

Carmel was someone who was always looking for opportunities to push the RANZCOG Pacific agenda forwards. Carmel was a key driver of the PSRH success.

PSRH and its Board can be proud of a distinguished set of achievements. It gives us a sense of community. The opportunities for networking have been amazing. Enshrined in the constitution are processes to ensure that the PSRH administrative processes are robust and transparent. Being members of the Trust Board carries legal responsibilities. No doubt all the members of the Board understand this.

The members of the PSRH Executive and Board have been elected because they are seen as leaders. As leaders they must share the administrative load of the organisation. Sadly, the track record is poor. I am sure the new Board will address this. Perhaps an orientation workshop for the Board will help. I understand RANZCOG has some expertise in this. But all organisations need grass root support from their membership. The Biennial Conference should not remain an opportunity without some contribution from the participants. Attending PSRH biennial meetings should not be seen as a free ride. Participants need to show their commitment by active participation. The new Board might wish to address this.

Finally, I want to recognise the contributions of people like Brian Spurrett, Roger Gabb, Jeremy Oats, Carmel Walker, Wame Baravilala, Glen Mola, John Ah Ching, Rufina Latu, John Wilson, Peter Stone, Roy Watson, Chris Kohlenberg, Caroline Homer and more recently Ai Ling Tan. Alec Ekeroma was the major catalyst during the period of PSRH's growth. His achievements since we first met in 1988 have been absolutely amazing. As for Karaponi Okesene-Gafa, she has a blend of Pacific genes which will ensure that PSRH's development remains in good hands.

PSRH has once again brought us all together. For it to be sustained we need to do our share in supporting our leaders. Brian my friend, your vision has been realised, and with the efforts of those charged with ongoing responsibility, it will continue. Thankyou my friend for bringing us together for the 14th time.

Emeritus Professor Rajat Gyaneshwar delivered the Brian Spurrett Oration with support from the RANZCOG Women's Health Foundation.

Letter to the Editor

Dr Duncan Howard

Ms Sara Newton

Ms Malia Lardelli

Dr Graham Slaney

Dear Editor,

The Winter issue of *O&G Magazine* focused on Lifelong Learning. We were interested to read this collection of interesting articles. In particular, the features from Dr. Judith Gardiner on GPO upskilling[1] and Dr Aggie Kujawa[2] on clinical attachments for RANZCOG diplomates, echo what we learned in a recent evaluation of Rural Generalist Advanced Obstetric Training in Victoria.[3]

While the RANZCOG requirements of the Advanced Diploma provide competence to practice independently, our interviews with former trainees, supervisors, and key informants highlighted the clear difference between competence and the confidence to do so, alone, in the bush, at night. This crucial aspect of General Practice Obstetrician/ Rural generalist Obstetrician (GPO/RGO) practice, expressed so poignantly by Dr Kujawa, was a recurring theme in our project.

Our participants' ideas about improving this competence-confidence mismatch reinforce what is expressed by Dr Gardiner and Dr Kujawa. These are in the areas of training time; skills consolidation; skills maintenance; and ongoing support and networking. We use the terms skills maintenance and skills consolidation rather than "upskilling", as we feel it more accurately describes what is required by the GPO/RGOs.

As a result of this project, we identified several action points that could contribute to the successful training and maintenance of a competent and confident GPO/RGO workforce. These findings and recommendations were presented to a forum of stakeholders on 1 April 2022 including trainees, supervisors, GPO/RGOs, and representatives from VRGP, ACRRM, RACGP, RANZCOG and the Department of Health. The recommendations were considered one by one by the group, and the resulting fruitful discussions gave very constructive feedback which has helped us revise and improve the action points.

Regarding the areas of training time; skills consolidation; skills maintenance; and ongoing networking and support, the following recommendations were made.

- Within each training post clarify and formalise the flexibility of completing the training full-time or part-time, balancing training vs service delivery, with flexible entry points and recognition of training time by RACGP and ACRRM.
- Quarantine and fund Consolidation of Skills posts; funding to follow the trainee to enable their identified learning needs with a robust mechanism to ensure funding meets the training plan of the trainee.
- Promote regional hospital engagement with GPO/RGOs to facilitate funded opportunities to pursue skills maintenance as per FRANZCOG accreditation requirements, apart from locum coverage.
- Increase awareness and support of the GPO/ RGO career choice via multiple mediums and stakeholders, with ongoing and funded networking opportunities between GPO/ RGOs, specialists, medical students, midwives, consumers, and health services.

We think these action points reinforce the arguments made in Dr Gardiner's and Dr Kujawa's articles and will continue to be pursued. Our goal is the same - to help ensure the ongoing viability of high-quality maternity services for all women in Australia.

References

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3. Sara Newton, Duncan Howard, Malia Lardelli, Graham Slaney. "VRGP State-wide Evaluation of Rural Generalist Advanced Obstetrics Training". Project funded through the VRGP by the Department of Health. June 2022.

RANZCOG Women's Health Foundation Scholarships and Awards 2023

The RANZCOG Women's Health Foundation proudly supports promising Fellows, trainees and academic researchers pursuing high-quality, innovative research and training in women's health. Research scholarships, fellowships and travel grants are awarded annually across Australia and New Zealand in recognition of those committed to continuous improvement in the fields of obstetrics, gynaecology, and the reproductive sciences. The Foundation strives to recognise researchers at different stages of their careers and, in particular, young researchers, to assist them as they progress their careers.

The RANZCOG Women's Health Foundation is pleased to announce the successful award recipients commencing their research and training in 2023.

RANZCOG NSW State Committee Trainee Research Grant

Recipient: Dr Fiona Li
Institution: University of New South Wales
Project: Discrete Choice Experiment: Determining Patient Decision-Making Factors in Management of Postmenopausal Vaginal Symptoms.

Brown Craig Travelling Fellowship

Recipient: Dr Tarana Lucky
Institution: IFEMENSO, Clinique Tivoli - Ducos Bordeaux, France
Project: To undertake a 3-month clinical training fellowship at IFEMENSO with a focus on surgical training.

Our scholarships and grants are offered annually in one round which opens on 30 April each year. For more information about awards commencing in 2024 please go to **https://ranzcog.edu.au/our-college/our-work/womens-health-foundation/.**

Thanks to our generous donors, our Scholarships and Grants program represents a significant philanthropic contribution to women's health training in Australia and Aotearoa New Zealand. If you would like to make a donation please go to **https://ranzcog.edu.au/our-college/our-work/womens-health-foundation/.**

Do you have experience working or volunteering in low- to middle-income countries?

Share your story in O&G Magazine

RANZCOG is committed to improving the health of women and their families, including in the Pacific region.

The College is seeking contributions for O&G Magazine about global women's health. Articles and opinion pieces that highlight women's health issues or initiatives in low- to middle-income countries are appreciated.

Don't have time to prepare a written contribution?
We can interview you and write the article for you.

Contributions are welcome from all College members.

For more information about contributing to O&G Magazine, go to: www.ogmagazine.org.au/contribute

Liam & Frankie Davison Award recipients 2022

Despina Demertzidis
Scholarships and Grants Coordinator
RANZCOG

Launched in 2015, the Liam and Frankie Davison Award celebrates youth and outstanding achievement in literary writing.

The Award was named in honour of RANZCOG staff member and award-winning author, Liam Davison, and his wife Frankie, a secondary school teacher, in recognition of their shared passion for nurturing and encouraging young writers.

Annually, the RANZCOG Women's health Foundation invites senior secondary school students residing in Australia or Aotearoa New Zealand to submit an original literary piece about an issue in women's health that interest them.

Past submissions have covered topics such as body image issues, endometriosis, postpartum depression, abortion, gender inequality and violence against women.

Now in its seventh year, the Award continues to attract high quality applications from students with a range of interests including medicine, science, health, sociology, politics or law.

The RANZCOG Women's Health Foundation is delighted to announce the winners of the Liam and Frankie Davison Award 2022:

- Annabel Lau of Hurlstone Agricultural High School, Australia (1st place)
- Lucy Corcoran of Emmanuel College, Australia (equal 2nd place)
- Lucy Thompson of TeKura School, Aotearoa New Zealand (equal 2nd place)

To read their award-winning entries and for more information about the award, please scan the QR code.

Annabel Lau

Lucy Corcoran

Lucy Thompson

Obituaries

Dr Peter Heath
1938–2022

It is with great sadness that we acknowledge the passing of Dr Peter Heath on 23 July 2022.

Peter was born at Richmond NSW in October 1938. His father, a Squadron Leader in the RAAF, died while serving overseas, so his mother became the primary carer of Peter and his sister.

Peter attended the Homebush Primary School and won a bursary to the Homebush High School. At school, apart from academia, he excelled at sport, specifically at shotput, cricket and tennis. He won the U16 NSW state schoolboy tennis championship.

He studied medicine at Sydney University, commencing at just 16. Peter was a resident doctor at Prince Alfred Hospital Sydney, but moved to Melbourne in 1962, where he was an intern at Prince Henry's Hospital.

Having decided to specialise in obstetrics and gynaecology, he began his training at the Royal Women's Hospital Carlton in 1963, subsequently becoming an assistant in the Professorial Unit under Sir Lance Townsend in 1965.

In 1966 Peter travelled to England and furthered his training under Professor Lyndon Snaith in Newcastle on Tyne. He also worked with George Pinker, who was the Medical Officer to Her Majesty Queen Elizabeth ll.

Peter returned to Melbourne in 1968 and was appointed Assistant Medical Superintendent of The Royal Women's Hospital. He was the youngest ever appointee to the senior medical staff there.

In 1969 he was awarded The King George V Research Scholarship for research into infant and maternal mortality. This involved the use of a recently-developed ultrasonic foetal pulse detector, which could detect the foetal pulse as early as 12 weeks gestation.

He was subsequently appointed Head of the Wednesday Obstetric Unit, which specialised in diabetes in pregnancy. He was renowned for his assessment and management of obstetric and maternal complications of diabetic pregnancies. He was skilled at manipulative obstetrics, and a great teacher.

Peter's career at The Royal Women's Hospital spanned some forty years.

He was, in 1976, a founding Fellow of the Royal Australian College of Obstetrics and Gynaecology.

Outside medicine, his overriding passions were horse racing, farming, and cooking. He was the Victorian Racing Club doctor at Flemington for many years, and later for Racing Victoria. His passion with horses led to him owning and racing several steeds.

His farming interest centred around Yea, Victoria, where he spent many happy years breeding and fattening cattle, and nurturing his roses and daffodils.

Another passion of his was cooking. He attended Victoria Market every week, purchasing items essential for his recipes from his favourite produce stall, delicatessen and butcher. He often provided cakes and tarts for the Wednesday Unit morning teas, enjoyed by consultants and trainees alike. He entered his plum puddings, jams and jam tarts in the Royal Melbourne Agricultural Society cooking competitions, winning several categories.

Peter served on the Yea and District Memorial Hospital Board and the Board of the Bendigo Bank, Yea.

In 2017 Peter was diagnosed with Lewy Body Dementia. This resulted in a slow decline, and he passed away on 23 July 2022 at The Rosebank Nursing Home in Yea, aged 83.

A summary of accolades from his colleagues includes: "a pleasure to work with", "calm", "extremely competent", "outstanding clinical judgement", "a gentleman and gentle man", "a respected role model", "great mentor and teacher", and "a wonderful quirky sense of humour".

Peter is survived by his wife, Jill, and his three children, Daniel, Ben and Catriona, and their families.

Dr Derrick Thompson, VIC

Dr Raymond Stanley Hyslop
1934–2022

It is with great sadness that we acknowledge the passing of Dr Raymond Stanley Hyslop on 22 August 2022.

Ray was born on 8 February 1934. Ray lived in Bardwell Park when the roads were unsealed and there was no sewer or telephone services. Ray had to walk to school through the bush across a low bridge over Wolli creek.

Ray was educated at Earlwood public school and then (on a full scholarship) at Sydney Grammar School. He then gained entry to Sydney University to study medicine, and on graduation was appointed Junior and then Senior resident medical officer at RPA hospital, and finally Registrar in Obstetrics and Gynaecology at King George V hospital.

During his training he met a trainee midwife, Helen Judge, who had trained at Royal Perth Hospital. In 1960 they were married, and remained together until she passed away in 2016. There were four children as a result of their union. Ray has left a legacy of seven grandchildren and one great-grand child.

Ray gained his Diploma in Obstetrics and Gynaecology (DGO) in 1961. In 1964 Ray passed his MRCOG, then FRANZCOG in 1978 and FRCOG in 1979.

Clinical appointments:
- 1963–1997 Honorary, Visiting and Staff Specialist at Liverpool Hospital.
- 1964–1967 Honorary medical officer- Fairfield Hospital.
- 1967–1975 Clinical Assistant- King George V Hospital.
- 1976–1975 First consultant Obstetrics and Gynaecology - Camden Hospital.

Administration:
- Liverpool Hospital Medical Staff Council several years as Chairman.
- 1974–1976 Chairman Camden Hospital medical board.
- 1975 Foundation Chairman Western Obstetrical and Gynaecology Society.
- 1973–1977 NSW State Committee, RCOG.
- 1983–1994 NSW State Committee, RANZCOG.
- 1985–1988 NSW State Committee Chairman, RANZCOG.
- 1992–1994 Member Australian Council RANZCOG – Honorary Treasurer.
- 1989–1991 President of Australian Society for Psycosocial O&G.

Army service:
- Between 1958 and retirement in 1989, Ray served actively in the CMF and Army Reserve. Retired as Colonel, his last posting was Chief of Divisional Medical Services, Commanding Officer 1 General Hospital.

Awards:
- Army – Reserve Force Decoration and Bar, National Medal, Australian General Service Medal and National Service Medal.
- 1994 NSW AMA president's award.
- 1996 Liverpool Quota club Citizen of the year.
- 1997 Liverpool Chamber of Commerce Businessman of the Year.
- 1997 Companion of the Order of Liverpool for services to the community.
- 2003 Awarded an Order of Australia in the Australia Day honours list for services to Obstetrics and Gynaecology particularly in the areas of teaching and administration.

If that weren't enough just to fill in time, Ray ran a very busy private practice and authored or co-authored 12 published articles.

Of a more personal nature, Ray loved to travel and loved trains, and sometimes combined the two with train journeys with St James Rail. He loved rural life and in the 70s and 80s he and Helen bred beef cattle and Australian stock horses, and in later years helped during the shearing at a friend's property in central NSW. He also had a great love of sailing and spent many years sailing with Helen and with the Lake Macquarie Cruising Club. He loved gardening and he always grew beautiful and fragrant roses.

In retirement Ray had an ongoing involvement in social groups and local community groups.

He retained a strong association with Sydney University Blue and Gold Club.

Finally, Ray was the driving force behind the publication in 2018 of the history of Crown St. Women's Hospital (closed in 1983).

Dr Peter Hammill, NSW

Prof Ian Harrison Kidd 1926–2022

It is with much sadness that I record the death of my father, Dr Iain Harrison Kidd, who passed away on Monday 12 September 2022 at the age of 96.

A founding Fellow of RACOG, Iain was born in the city of Rangoon, Burma (now known as Myanmar) on 21 March 1926. His parents were in Burma at the time for his father's work as a superintendent engineer. When he was 3, his parents decided to return to Edinburgh, Scotland. I often wonder if this early experience living in such a fascinating country was to influence him in travelling far and wide throughout his life!

Educated at George Watson's Boys College in Edinburgh, he received his school certificate at 16 and then went to Edinburgh University. He started his degree in medical sciences in 1942 and qualified in medicine in 1949. His Diploma in Obstetrics from the Royal College of Obstetricians and Gynaecologists (D.Obst. RCOG) was granted on 24 November 1951.

Iain started his professional medical career in Lancashire, UK. He spent two years in the army, where in a specialist hospital for the Northern Command he was made a clinical officer in obstetrics and gynaecology, before being posted to Hong Kong. Whilst in Hong Kong he was mentored at the Queen Mary Hospital by Professor Gordon King.

In 1953 and out of the army, Iain continued building his knowledge and experience in Manchester, Edinburgh, Hull, Birmingham, and Sheffield. After answering a medical journal advertisement, he spent two months in Germany with the Canadian Air Force medical corps.

Returning to Manchester, Iain found many of his peers were seeking opportunities outside of the UK. He had come across many Australians and New Zealanders in Hong Kong and northern England. He liked them greatly and believed that there was opportunity for him in the southern hemisphere.

Iain arrived in Sydney on Anzac Day 1960. Upon his arrival he went to Mt Gambia, and then after a year, moved to Hobart. In 1964, married with one child, and another on the way, he found himself in Newcastle, New South Wales, where he became a member of the western Newcastle obstetrics and gynaecology medical community for over 20 years. Iain delivered many babies and helped many women with their health and was always surprised when a new patient came to him and told him that he had also delivered her!

Between 1984 and 1991 Iain and his wife, Coralie, a trained midwife and nurse, lived and worked in Tabuk and Khamis Mashait, Saudi Arabia, and Gander and St Anthony, Newfoundland, but returned to Australia often to fulfil locum assignments in regional New South Wales. In 1991, Iain and Coralie ended their international endeavours and finally returned to Australia, landing in Coffs Harbour, and became part of its medical community.

Iain leaves behind his wife, Coralie, his children Alison, Duncan and Gillian, grandchildren Rebecca, William, Lachlan, Maddison and Callum and a great-grandson, Freddie.

Dr Iain Harrison Kidd was interviewed and recorded by Struan Robertson for RANZCOG Oral History in 2009.

Alison Beaumont, NSW (Prof Kidd's daughter)

Emeritus Prof Eric Vincent Mackay 1925–2022

It is with great sadness that we acknowledge the passing of Emeritus Professor Eric Vincent Mackay on 19 August 2022.

Eric was a giant among his peers in many ways. He was awarded membership of the Order of Australia for "significant contributions to medicine as an educator, clinician and administrator".

Eric obtained his medical training and pursued an academic career at the University of Melbourne and Royal Women's Hospital in Melbourne until 1964. At this time, he was appointed the inaugural Chair in Obstetrics and Gynaecology at the University of Queensland in Brisbane, and continued as Head of Department for a record 25 years until his retirement.

Eric was well-accepted in Brisbane and quickly made his mark as an intellectual and clinical leader. His contributions were many, and best shown in these three examples:

He had a great talent for precise scientific writing and appreciation of good research. This was recognised by our College when he was given the responsibility of promoting reporting of research as Editor-in-Chief of its journal, for which he was highly regarded and held the position for many years. He was known for his gentle guidance and patience with young researchers to improve their papers for publication.

His expertise in clear writing and sound clinical reasoning translated into a career-long interest in the promulgation of medical education and its need to question dogma in teaching. He recognised the important interface between scientific knowledge and clinical care, and the relevance of scientific basis in management. He spent hours and days (and years) in producing a popular *Textbook of Obstetrics and the Newborn*, and *An Illustrated Textbook of Gynaecology* for students, in partnership with his good friend, Norman Beischer. The books' acceptance in Australia was evident by the many editions.

He was also an exemplar of the rare breed of competent academic-clinicians; his surgical skills were sought after by the hospital community. He had a special interest in gynaecological oncology; this made him work very hard to convince Queensland Health to recognise the value of formalised care for patients with gynaecological cancer. He spent hours in the operating suites with his good friend, Keith Cockburn, in developing techniques in cancer surgery. They sponsored the formation of centralised care, integrating the combined expertise of gynaecologists, radiotherapists, medical oncologists and even social workers, and initiated the formal training of oncology surgeons in gynaecology.

Eric led a rich life of 97 years – living up to a reputation of being an honourable gentleman. He endeared himself to his devoted wife, Gae, his two children, and friends (not only of the two-legged kind, but also the four-legged; his passion for horses was well-known).

Emeritus Prof SooKeat Khoo AM, QLD

Prof Richard John Seddon 1934–2022

Richard (Dick) Seddon died peacefully on 21 October 2022, just weeks after his 93rd birthday. He had a long and distinguished career in obstetrics and gynaecology.

Dick was born in Pukemiro (near Hamilton) in 1929. He attended Hamilton Boys High School before he entered medical school in Dunedin, graduating in 1954. One of his infamous memories from student days was when he was thrown out of his boarding house for euthanising his landlady's long-suffering elderly dog. She had read his diary and he found all his things on the George street footpath when he returned home after lab classes one snowy night.

As a house surgeon in Hamilton, he met Barbara who was nursing there, and they married in December 1956. He originally wanted to be an orthopaedic surgeon but was convinced to begin training in O&G, and was offered a job at National Women's Hospital in Auckland. But before he could start, the mentor who offered the job died, and so he had no job after all! So he went to Dunedin in 1958 to begin his training under Professor Lawrence Wright. He won the O&G travelling scholarship that took him to UK. In 1959 he, Barbara and their first child, Annette, set off to UK on a Port Line vessel, with Dick as the ship's surgeon.

He worked in Welwyn Garden City, and after obtaining his MRCOG, continued his post graduate training at the Newcastle-upon-Tyne University hospitals, where he worked for four years. Their second child, Philip, was born there. In 1964 he was offered a consultant post in Newcastle-upon-Tyne, but turned it down because he thought the air quality at the time would doom his two young kids to chronic bronchitis.

Prior to returning to New Zealand in 1965 he had been offered a locum position for the legendry Mont Liggins, but found on his return that there was no money to pay for it. It was a temporary setback, for he was soon appointed to a position at Auckland University where he began a successful academic career, initially establishing obstetrics and gynaecology in the curriculum of the very new medical school. His career specialty was in reproductive endocrinology and he was a very accomplished surgeon. Amongst his other early accomplishments was the introduction of laparoscopy to New Zealand, and he performed the very first procedure from a makeshift laparoscope made from a culdoscope.

Dick was appointed to the foundation Chair of Obstetrics and Gynaecology in Wellington in 1975. It is intriguing he shared the same exact name as New Zealand's longest serving Prime Minister, and it is ironic that where the Premier Dick Seddon introduced the St Helens' Hospital network in New Zealand, it was Professor Dick Seddon who had an influence on their closure. With the building of a new high tech women's hospital in Wellington it wasn't logical to have both the new hospital and

the old St Helens. Contrary to the accolades for the Prime Minister Seddon for making St Helens possible, it was RJ Seddon, gynaecologist, who got the flak from the public outcry for 'closing' them! As it happens, Dick was a distant relative of the famous Prime Minister – his grandfather was a cousin.

Dick moved to Dunedin in 1981 as the University's third Professor of Obstetrics and Gynaecology. He was an inspiring teacher and his legacy in teaching obstetrics was his idea that pregnancy was an interaction between the fetus and the mother, and the fetus was the dominant party. This is now universally accepted, but at the time was radical thinking.

From the time of his first professorial appointment, his service to obstetrics and gynaecology grew immensely, serving on numerous governing bodies in New Zealand and internationally. These include his Presidency of the NZ College and working for the World Health Organisation on the Maternal and Child Health committee. Perhaps his most important achievement was the work he did for the Asia and Oceania Federation of Obstetrics and Gynaecology, leading the design and content of its education program. This Federation is an amalgamation of all the Colleges of Obstetrics and Gynaecology in Oceania and Asia. He would have become its President if he had not health issues that also shortened his time in Dunedin. He remains as one of Federation's 18 Fellows; only 18 can be held at any one time for living members.

Ill health forced an earlier university retirement in 1991 than he planned but he did continue to work for another four years as Head of Department at the King Faisal Hospital, Riyadh, Saudi Arabia where he taught O&G to women graduates.

He and Barbara returned to Dunedin in 1995 and in 1999 shifted to rural Queenstown where they had built a new house. On every move he made in his life he established a garden. Rural Queenstown was no exception when he set to on an 8 acre property. He had been told olives couldn't be grown there so he decided to plant them anyway. The olives didn't work out, but his gardens had everything else: hazelnuts, chestnuts, almonds, plums and apples. Sadly, Barbara died in 2001. Dick eventually shifted, with his partner Chris, to Dunedin in 2014 where they resided at Brookland Village. Apart from gardening, his other hobbies included clay sculpting and drawing. He played croquet for many years and was an avid traveller before and after retirement.

Dick leaves behind his partner Chris, his children: Annette, Philip, Michael; grandchildren: Peter, Connor, Liam, Jasper, Shea; and great-grandchild, Ada.

Emeritus Prof Wayne Gillett, NZ

Dr Richard Allan Speed 1947–2022

It is with great sadness that we acknowledge the passing of Dr Richard Allan Speed on 9 May 2022.

Richard was born in Wellington, New Zealand on 21 December 1947. Following his secondary education at Wellington Boys College, he completed a Bachelor of Science at Victoria University Wellington. He then completed a medical degree in 1973 at the University of Otago.

By 1975 Richard was ready to travel and, after a short visit to the UK, travelled overland in Africa to arrive in South Africa for a job at King Edward Hospital, Durban. This was a very large teaching hospital and the start of Richard's career in O&G. Richard travelled extensively to game parks over the next couple of years indulging his passion for fauna and flora.

Having completed his part 1 in South Africa, he moved to Glasgow, Scotland to complete his training. Some of the time was spent at Bellshill Maternity Hospital where he met Tia, an Irish nurse completing her midwifery training. He returned to New Zealand and Waikato Hospital with Tia for his final clinical time and she worked alongside him in the labour department. He became a member of the Royal College in 1980 and the Royal New Zealand College in 1982.

Richard and Tia moved to Tauranga, Bay of Plenty in 1983, following the birth of their first child. Richard worked as a consultant in both public and private for the next 35 years. Richard was a people person and thoroughly enjoyed the rich multicultural workforce he was a part of. He was devoted to all his patients and to women's health. He strived to reduce any medical inequality for Māori women over his career through his work at dedicated clinics. Richard was a long-standing member and past president of the New Zealand Medical Association and was involved in women's health in the Pacific.

Outside of work, Richard was passionate about the environment and involved in many working groups. He and Tia did some world travel in the years leading up to and just after retirement, which was fortuitous, as sadly ill health followed.

Richard is survived by his wife Tia and children Christopher, Rowena, Elizabeth and Amanda, and three granddaughters Edie, Florence and Piper.

Tia Speed, NZ (Dr Speed's wife)

Remembering Our Fellows

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

- **Dr Iain Harrison Kid**, NSW