Bulletin

NEWSLETTER OF THE RETIRED FELLOWS AND MEMBERS SOCIETY

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Reflections on obstetric care

Tony Falconer FRCOG, former President of the RCOG reflects on the changing nature of obstetric care and what is required to deliver services that meet both professonial and patient needs.

Moving from active clinical practice to a new phase of life, there is self-reflection, mixed emotions, including a sentiment of how fortunate we were to work in the NHS during 'our' particular period. We kid ourselves that 'things were better in my day'! Is this a distortion of reality? It is apposite to examine its validity in the light of the pressures on obstetric and maternity care now, before the publication of the separate reviews of maternity services in Scotland and England later this year.

I started postgraduate training at the Simpson Memorial Maternity Pavilion (SMMP) in Edinburgh in 1974. We had four consultant units, a co-located GP unit and we covered a number of GP units throughout the borders through the obstetric flying squad. The comparison with today is stark: one unit within the city, housing a very busy consultant led unit (CLU), a midwifery led unit (MLU) and units in the Borders and West Lothian providing for their own populations.

The challenge to politicians, planners, managers and front line clinical staff providing healthcare to our population, larger in numbers, older with multiple co-morbidities (including obesity) is of such magnitude as to be a real challenge without considerable restructuring within the current fiscal constraints. The need to provide safe maternity services, following national quality standards, has forced service providers to examine where and by whom women's healthcare should be delivered.

Before reconfiguration of clinical services are implemented, there must be public and patient engagement, patient choice protection, evidence based support from commissioners, clear articulation of benefit to patients, implementation of best practice and an options appraisal including a review of networking arrangements.

Birthplace studies by the National Perinatal Epidemiology Unit suggest that for selected women, defined as 'low risk', MLU delivery is appropriate for about 30% but planners need to build in a peri-partum transfer rate of up to 40%. The RCOG has always supported such development, with emphasis on increased proximity and safety of co-location rather than standalone MLUs. Uniquely in healthcare, choice of location of delivery for women can create its own tensions. Replacement of some small CLUs by MLUs, offers a service much supported by the community, provided there are in built safeguards including transport facilities.

Multi-professional working of obstetricians and midwives has always been a beacon of good clinical practice, but contemporary obstetric care requires a much larger team to provide high quality care to the increasingly high risk population it serves. Paediatrics, anaesthetics, surgery, medicine and imaging are all disciplines required for care in CLUs today. With the need for such services to be delivered by accredited specialists onsite, come their own pressures. 24-hour labour ward presence by consultants in large obstetric units requires expansion of the consultant grade and modelling suggests that such a development needs an increase in the consultant body of 30% which seems unattainable within current training and financial constraints.

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The design of service reconfiguration is proving to be a significant pressure point for our Royal Colleges and sister organisations, in providing independent advice to Clinical Commissioning Groups and trusts. Balancing needs and aspirations of communities with the most efficient design of healthcare can disadvantage the very people we are trying to support. Creating an 'ideal' sized maternity unit to meet medical needs is easier in South London, compared with remote, isolated villages in the Scottish Highlands, rural Wales or in Cumbria. Balancing MLU provision and CLU care is easier in inner cities, whilst in rural areas, ambulance services and transport infrastructure are vital to guarantee safety.

Financing such provisions relies on the maternity tariff in England and health board provision in Wales and Scotland. In England the maternity service may rely on gynaecological revenue to balance the books. Also, the standards of care and staffing, recommended by our and other Royal College guidelines, will

create difficulties with job planning. The presence of someone with advanced airway skills for neonates within 10 minutes of delivery presents a massive challenge to a consultant based obstetric unit delivering only 1,000 women.

Maintaining sustainability in small units requires imaginative job planning that is professionally attractive to the consultant workforce, given that many specialists want very different patterns of work, from part time to portfolio working. Creating a sustainable workforce in both very busy and 'quieter' units will be challenging– the prospect of 24-hour cover in a hectic unit with over 7,000 deliveries may be attractive for a few years, but will be less attractive in your fifties. Anecdotally, large units may be professionally challenging, but quieter units make it difficult to maintain competencies and present other challenges. As such, consultants in smaller units may choose to focus on simulation and rotations to busy units to maintain clinical skills.

The consistency of these challenges, concerning reconfiguration, has been apparent in several areas of work that I have been involved with during this year. There is no dispute that women want safe services as close to home as possible even, on occasions, at the cost of quality. One model does not fit all, but current funding arrangements in England are not helpful in creating the best maternity services for women.

Have maternity services improved since 'our' day? The evidence suggests that improved team working and constant simulation training such as that offered by the Practical Obstetric Multi-Professional Training (PROMPT) programme will improve outcomes for women and children. The real challenge is creating stimulating, rewarding employment where one feels part of a team and develops some form of continuity of care, even if the structures around you change. Breaking down hierarchies with close, respectful, working with midwives and other members of the extended maternity team, is essential for the most favourable outcome for both mother and baby.

Spotlight

Patrick Taylor MD FRCOG

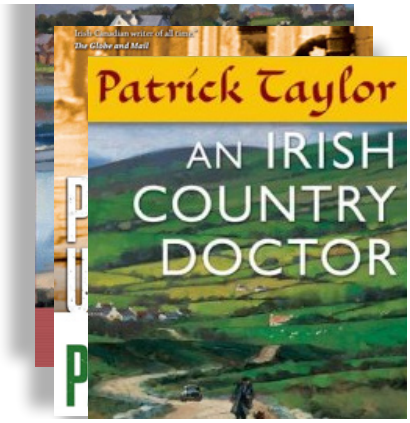
Patrick specialised in human reproduction, working at three Canadian universities before retiring as Professor Emeritus at the University of British Columbia in 2001. He has published twelve novels, a collection of short stories and an anthology of humour columns. He lives on Saltspring Island, British Columbia, Canada.

I was invited after retirement in 2001 to write an editorial, *'Is there life after gynaecology?'* Please let me tell you what I think. As someone from the pre-television generation, I have always been intrigued by the written word. This is something that stood me in good stead during a thirty year academic career at the Universities of Calgary, Manitoba, and British Columbia where I was co-author of six textbooks and more than 100 original papers.

My speciality at that time? As my six year old daughter told her classmates when asked, "What does your daddy do?" she replied. "He makes ladies pregnant."

For 10 years, I also served as editor-in-chief of *The Journal of the Society of Obstetricians and Gynaecologists of Canada*. Beginning in 1990, I was invited to contribute regular humour columns; I think some one had read my paper on *'Infertility in the Lowland Gorilla,'* to *The Canadian Medical Association Journal* and *Stitches: the Journal of Medical Humour.*

By the mid nineties I confess that I was tiring of the dry constraints of scientific writing. I unearthed a short story I'd written back in 1969 about the Troubles in Northern Ireland, wrote three more and sought advice from our journal's publisher. He showed them to the owner of a now defunct, but then well thought of Canadian publishing house. She asked for 12 more stories and my first work of fiction, *Only Wounded: Ulster Stories* was released in 1997.



I then tried my hand at long fiction. Eight hundred manuscript pages and several rejection letters later my attempt was shredded. With encouragement from other writers I tried again. Deliberately avoiding using my medical background, but instead relying on a long-time interest in Ireland's (and particularly Ulster's) history I crafted *Pray for Us Sinners* – a novel of loss of faith and search for atonement set against the background of the thirty years of internecine strife. To my intense delight it was accepted and appeared in 2000.

I then tried to get my editor to bind ten years worth of humour columns, but she rightly explained that anthologies only succeed if the author is well known like Giles Coren. Clearly I was not. She suggested I develop the main character from the columns, Doctor Fingal O'Reilly, a crusty, middle-aged country GP in rural Ulster.

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Thus was born *The Apprenticeship of Doctor Laverty.* It did reasonably well in Canada. Next came the sequel to *'... Sinners'* then to my amazement I received a call from an acquiring editor at an imprint of MacMillan's in New York. She wanted to acquire the rights to *'...Doctor Laverty'* which was re-published in 2007 as *An Irish Country Doctor.* It became the first of a nine book series, six of which have been *New York Times* bestsellers. Number ten will appeared in October 2015 and 11 is with my publisher ready for 2016.

The changing face of medical education

Bulletin Sub-Editor, Jack Wingfield FRCOG discusses the changing face of medical education with Dr Steve Riley of Cardiff University.

Jack Wingfield FRCOG

Jack introduced fetal cardiotocography and intrapartum monitoring in his unit in 1970, set up the ultrasonic scanning unit and started one of the earliest endoscopic gynaecological surgery units in London. Jack retired in 1997 and is now the sub-editor of the RFMS Bulletin.

I graduated from the Welsh National School of Medicine in 1959, now the Medical School of Cardiff University – a university in its own right since 2005. Medical education in my day was split into three parts: a pre-medical year (usually 'skipped', with A-levels in school), two pre-clinical years of basic sciences (anatomy, physiology and biochemistry, etc.) and three clinical years followed by a pre-registration year after graduation. I asked Dr Steve Riley, Programme Director at Cardiff University School of Medicine, whether this arrangement still stands and was met with a very definitive 'No'! Although it is still the pattern in many schools, Cardiff has looked to the future in the light of the NHS's need to expand the service, the demand for 24 hour availability of GP and hospital services, the European Working Directive, the resultant need to change from consultant-led care to 'team care' and has changed the pattern of student education. As a result, Cardiff has scored very highly in student surveys.

Some six or seven years ago, he says, a national student survey rated Cardiff as 'poor' for student education. Then Professor John Bligh came in with new ideas. The pre-medical year is still available, but not commonly taken up, but the subsequent format has changed to clinical contact starting almost from day one. In the first year teaching is 70% basic science, 30% clinical science, changing proportionately over the next five years. Basic sciences are revisitied in the later years of the course to reinforce the link between science and clinical work. This early clinical contact puts both elements into context, still having access to dissection, 'prosections' etc, but allowing modern techniques (e.g. radiology, scanning) to enhance the relevance of anatomical structure. There was some concern related to final exams, in that students may 'work for exams' and not for the benefit of patients. The principle is still to have 'finals', but to have major assessments at the end of the fourth year of the course so that students know whether their knowledge is adequate. Year five is then all about preparing for practice.

Students are supervised through the final year using clinical placements, the aim being to smooth the transition from being a student to being a doctor and to improve patient safety (records reported by the Royal College of Physicians have shown a 6% higher patient mortality following the August student/houseman transition of the past) and the change has been shown, statistically, to be successful. It reduces anxiety, to some extent, for the new doctors and gives more confidence in carrying out appropriate treatment/management. The aims remain: to teach the prospective doctor to be a reliable reporter, interpreter, manager and communicator, so that their patients have confidence in the care they are receiving.

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When we qualified, we were part of a consultant led team and as pre-regisration House Officers, continued to learn by following 'the Chief', watching patient management and being taught by the more senior members of 'the firm' until we were formally registered after twelve months. The medical school is still responsible for the first placements of their graduates, but whereas we were appointed to units in or close to Cardiff, they may now be almost anywhere in the UK, so monitoring has become much more difficult.

The Cardiff protocol aims to be ahead of the changes coming into medical practice in the NHS. The increase in patient expectation, the demands for 24 hour acute medicine, the increase in chronic disease associated with an ageing population, the need to admit and discharge patients over a short time scale and the increasing need for care in the community, are changing medical practice and the new programme has shown that the foundation doctors feel better prepared for practice.

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The other side of the coin, however, is the lack of continuity of care and the difficulties of specialist trainees gaining experience. The concept of junior and senior consultants is almost a pre-requisite for the specialist of the future.

My 'Old College' is in the vanguard of change to meet the needs of the future health of the nation and in recent student surveys is now rated ninth in the Guardian Guide and third behind 'Oxbridge' by the Complete University Guide.

Dr Steven Riley

Steven is Programme Director for the C21 Programme, Cardiff University School of Medicine's project to update its MB BCh programme. In 2014 he won the prestigious Enriching Student Life Award from the Cardiff University Students' Union while in 2013 he won the School of Medicine's Teaching Excellence (NHS) Award.

Spotlight

Anna Glaiser OBE FRCOG

Anna worked as Director of Family Planning & Well Woman Services for Lothian until 2010, she is an honorary professor at the London School of Hygiene and Tropical Medicine and the University of Edinburgh. She works with a number of international organisations including the World Health Organisation. In 2005, Anna was awarded an OBE for services to women's health.

When I retired, I decided to improve my French language skills. I learnt French at school, but have had little opportunity to use it since then, beyond asking for 'une assiette des frites' during ski holidays.

I wanted to find a 'somewhere' that concentrated on conversation. Friends who had been to places in Provence, Montpellier and Tours all complained that the week was exhausting; the teachers were absolute sticklers for correct grammar and there were lots of young students there for three to six months who were disinterested.

I ended up at L' Ecole des Trois Ponts, a small language school in a little town called Roanne on the Loire. It was superb. It is housed in a large old house down a quiet lane on the outskirts of the town. It has 10 modern bedrooms (each with its own shower room) opening on to a large sunny garden.

You can stay in local hotels or with a French host if you prefer. The main building houses the classrooms, a large dining room and a salon with loads of books and DVDs. Full board is provided by a cordon bleu chef who also teaches cookery at the school. The food is delicious.

You are asked to speak French at all times and a teacher joins the group for lunch and dinner to make sure this happens. The chef also joins in – no French, no dessert! The classes are small (a maximum of six) and usually only about 15 students in total. An online French test allows Valerie (the boss) to determine how many teachers they need for the week.

On the first morning you have a quick conversation with Valerie who decides which class you should join. The general course involves classes all morning (9.15am-12.30pm) and on two evenings from 5pm-7pm. The classes are great fun.

One example – each student writes a list of words; a date, the name of a celebrity an animal, an item of clothing, two verbs, a word 'you have learned this week' etc. The lists are shuffled and distributed and you have 15 minutes to write a story using all the words on the list you received.

> *"You are asked to speak French at all times and a teacher joins the group for lunch and dinner...The chef also joins in - no French, no dessert!*

The teachers are excellent. The school is very flexible. Many people do the general course and add on three afternoons of one-to-one private tuition. On a cookery week you do French in the mornings and cooking from 4pm. It is not a cookery school where you each have your own stove and kit, rather a cookery demonstration with some hands on interaction – but all in French.

The countryside around is very pretty, but for that you need a car. Many people return, some go every year. When I decided to return my husband advised that if you have a great time somewhere and then you go back it is seldom as good. My second week was even better and I am going back this year for a third time!

If you are interested in finding out more, visit: www.3ponts.edu

Noticeboard

Get Involved

We are eager to hear from retired Fellows and Members who would like to contribute to this Bulletin. This may be in the form of an article, news story or an item of interest you would like to share with your colleagues. If you'd like to get involved, please contact James Cross (jcross@rcog.org.uk). The next issue of the Bulletin will be published in March 2016.

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