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*About the front cover:* The dandelion with spreading seeds was selected as a symbol of the change the RCOG is undergoing and of the work the College does to communicate with its members and the women they care for worldwide.
From the President

We live in a world of huge change. Within the National Health Service (NHS) we are witnessing the greatest reorganisation in 60 years. On a lesser level, the RCOG has undergone a rebranding exercise over the last 2 years in an attempt to make our communication structures more streamlined. This has included a review of the *RCOG News*; it is hoped that the new format, *Membership Matters*, will be well received by all Fellows and Members. Within the RCOG, we have said goodbye to Ms Beryl Stevens MBE, who has retired after 36 years of contribution to our activities. We are so proud that this contribution was rewarded by the appointment of an MBE to Beryl. Fellows and Members should make a note in their diary for the dinner in July when we will formally acknowledge her contribution.

This first issue of *Membership Matters* looks at various topics which I hope you will find useful and interesting. Our ever enthusiastic librarian and archivist have dug through the College records to produce a history of the College coat of arms and the President’s letter. Both of these articles mark the new phase that the College is now going into, by looking back at how we got to where we are today with regards to our branding and our newsletter.

Also of interest is an article about mentoring, which is an essential component of current team working. Many of you will already be engaged in mentoring; some of you may not even realise it. Giving advice and guidance to those who are in need of it is a good way of improving the confidence and skills of colleagues while providing a solid foundation for strong services and patient care in the future. I am sure you will agree that this is a valuable component of our current responsibilities.

One of our Fellows from Australia has taken the time to share his current lifestyle in the specialty with us. I dare say he is perhaps even busier with his retirement schedule than many of us are in active practice. Kim Boo, who is in his 70s, talks about going sky-diving and spending much of his time flying all over the country assisting in various clinics, practices and hospitals. His story is rather inspirational and makes for an interesting read. It is good to know that the best times are still to come once active practice ceases!

There is also an item about robotic surgery and the benefits it can provide to gynaecological procedures. While there are many who are traditionalists when it comes to surgical skills and procedures, the growth of robotics is rather substantial and it is interesting to know how far along the field has come. Although hugely expensive in terms of the initial outlay, early data suggest that these facilities should be available in some centres to provide highly specialised care, such as radical hysterectomy for cervical cancer.

The current team of Officers has been in post for 4 months. It is a time of great challenge and change and we are relishing the opportunities to influence thinking. Being President of the RCOG is a huge privilege and the delivery of the workload relies on significant support from others. My trust at Plymouth continues to support me even though I perform only 1 day of clinical work per week. However, that day allows me to maintain contact with patients and clinical staff and helps me keep in touch with the day-to-day worries of trainees, consultants, midwives, nurses and the women we care for.

I would like to finish by saying that *Membership Matters* is for you, the membership, and we encourage you to suggest articles and send in your ideas for items you would like to see. It is hoped that this is the start of something whereby the College can engage with you better and provide a platform for sharing with your colleagues worldwide.

Congratulations to Beryl Stevens on her recent retirement from the College as Deputy Chief Executive and Director of International and Corporate Affairs. Beryl has made a huge contribution to the work of the College during her long and successful career here.

If you would like to join us to celebrate Beryl’s achievements during her 36 years at the College, do please come along to the RCOG Dinner on Friday 22 July. Tickets are available from the Facilities Department priced at £65.00 per head.

For further details, please call Jayne Lawrence on 020 7772 6266 or refer to the website: http://www.rcog.org.uk/what-we-do/membership/fellows-members.
Dr Rebecca Viney is Coaching and Mentoring Lead at the London Deanery. In this article she tells us about some of the aspects of mentoring, a very important area in developing the skills, confidence and attitudes of junior doctors as well as improving the future of medical services.

Coaching and mentoring are methods of developing an individual’s capabilities and releasing their potential to facilitate the achievement of personal and organisational success. These methods can be used to manage talent and make good doctors even better.

Coaching and mentoring both focus on personal, professional and career development. Coaching tends to be shorter term and more task orientated and mentoring is more usually a longer relationship, but there is a great deal of overlap between coaching and mentoring skills.

In the past decade, there has been enormous growth in the field of coaching and mentoring as organisations increasingly recognise their value. A recent learning and development survey by the Chartered Institute of Personnel and Development suggested that 72% of organisations in the UK find them to be highly effective tools for development and have made them available to staff. Despite the economic climate, 70% of respondents indicated that expenditure on coaching had increased.

Why now?
In the current global economic climate, hospitals everywhere are expected to maintain services and reduce cost while improving performance and the patient experience. Coaching and mentoring can have a significant impact on staff members’ capacity to function in this environment. In 2004, a Department of Health paper concluded that the benefits of mentoring can be felt by doctors at all stages in their career. The paper also concluded that the process had real benefits for both mentees and their mentors. Mentees commented on improved reflection skills, support for dealing with specific problems, strategies for coping with change or crisis in their professional lives, improved self-confidence and more job satisfaction. Mentors also reported increased job satisfaction and improved relationships with patients, colleagues and family members.

The report therefore recommended that there should be a well publicised contact point for information about mentor availability in each trust, postgraduate deanery and medical Royal College, and that organisations that do not provide their own mentoring arrangements facilitate doctors’ access to appropriate programmes and schemes.

In 2010, the British Medical Association’s Joint Medical Consultative Council consulted widely and then published *Mentoring for consultants: a national framework for the NHS*, which recommended that mentoring be promoted as a positive development tool by which doctors can enhance their careers and that consultants should be able to undertake mentoring as a programmed activity within their job plan. The report also said that ‘At a time of increasing financial pressures and limited resources within NHS, we believe that the potential benefits outweigh the costs of setting up and running successful mentoring schemes in the long-term.’

Also, a lot of work has been done on improving patients’ experiences, in particular their experience of care in hospital. To deliver care and compassion, staff need to experience it themselves. This is where mentoring fits in. By offering compassionate mentoring and coaching, we heal the physician, prevent burn-out and provide a model for compassionate care.

My experience
I have been Coaching and Mentoring Lead at the London Deanery for 3 years and we have had 800 applicants go through the service.

When I initiated the service, I set up 12 principles, which I have continued to hone over time with input from all those involved in the scheme. The 12 principles are voluntary participation; confidentiality; externality; choice; mentee preparation; trained mentors; ongoing support; ethics; avoidance of dependence; no blame; monitoring, evaluation and review; and contracting.

There have been various surprises and lessons learned over the years. The mentoring and coaching service undoubtedly helps the mentees, but there are benefits for the mentors as well. The mentors involved in the service have seen their careers take off, with a range of skills being developed. As
A note about the London deanery

The aim of the London deanery is to foster a culture of talent management within the NHS. In London we aim to build a pool of talented individuals who can develop their own and others’ talents.

In April 2010 we received our 500th application to the coaching and mentoring service, and this seemed a good time to report on the way we set up the service and the lessons we have learned on the way. I commissioned a passionate coach and mentor, Professor Elisabeth Paice, to write the report with me. The report is available online through the London Deanery website: http://mentoring.londondeanery.ac.uk/news/the-first-500-a-new-publication-from-london-deanery-coaching-and-mentoring.

We have also created a podcast of some live mentoring and interviewed some mentors and mentees. The podcast is also available on the website: http://mentoring.londondeanery.ac.uk/useful-resources/podcast.

Potential issues

It is important to remember that there are some individuals who may not be suitable for coaching. This may be because their problems are best dealt with by another type of intervention, or it may be that their attitude interferes with the effectiveness of coaching. So, before beginning coaching, it is recommended to assess an individual’s readiness. Some examples of situations where coaching is not an appropriate intervention are if the individual has psychological problems, is resistant to coaching or lacks self-insight. Coaches should also be supported by supervision arrangements and effective quality assurance and evaluation arrangements should be in place.

Conclusion

In the last few months there have been several papers published about coaching patients for health, with astonishing results. The logical conclusion is that coaching patients is much more effective than advising them; this is the central tenet of coaching and mentoring.

Therefore, in a growing number of medical schools both in the UK and internationally, medical students are being taught basic coaching skills to enhance their teaching and their support of colleagues, to help them work effectively in teams and to empower patients to care for themselves; in time, it will also help them to develop as leaders.

By offering compassionate mentoring and coaching, we heal the physician, prevent burn-out and provide a model for compassionate care

It was Rahm Emmanuel from the Obama administration who, referring to the economic crisis, first said, ‘you never want a serious crisis to go to waste… It is an opportunity to do things that you think you could not do before.’ In this current climate of radical reform in health care, we strongly recommend that all doctors use and learn about coaching and mentoring to release their potential and remain resilient.

For more information about mentoring and coaching, I recommend three recent reports:


References

The change... of life

Dr Kim Boo Kuah FRCOG is a 75-year-old semi-retired doctor who jet-sets all over Australia working in various hospitals. He still has an active life including sky-diving and fishing.

The change – not quite menopause, but maybe a touch of andropause! The fact is, back in November 2003, my life was about to morph. I had decided to move on from my busy private practice – some would call it retirement. My ex-trainees were fast filling the positions in the department and I felt I had had a fulfilling 41 years of professional life. At one point, I was committed to a busy practice, contracted to other hospitals, working as a commissioned specialist reserve officer in the Royal Australian Air Force, examining and undertaking many other activities, professional and non-professional.

I was 68, so I did the right thing: put my financial matters in order and warned my sports physician son that he was going to get busier and I was going to have all the time in the world for golf! Then it happened. I received an urgent call to Broken Hill, a mining town. It was indeed in need of help as there was no permanent obstetrics and gynaecology person. I was on a fly-in fly-out rotation with other doctors, or FIFO, as it is known. In Broken Hill, as well as looking at Pro Hart paintings and the Living Desert, I also managed to convince the operators to relay any urgent call to me down in the mine so that I was able to go down a mine shaft!

The reasons I continued locuming are my love for the work and my inability to say no. Furthermore, obstetrics is a demanding mistress: unless one has sufficient practice, one soon gets de-skilled and loses a certain degree of confidence. There is also a desire in my inner self to help look after women in remote hospitals and allow others to have much-needed vocational and educational leave.

Not wanting to change my retirement plans of travel and relaxation, I decided that I would do some 26 weeks of locum work a year, with occasional volunteer work. My weakness resulted in my working some 40 weeks a year. In the last 3 years, my wife and I have slept in our Sydney home on only 200 nights.

In these 8 years I have worked from Darwin and Gove in the north of Australia to Burnie, Tasmania in the south, and from Broome on the west coast to Townsville on the east coast. All in all, I have worked in some 25 hospitals, each delivering between 200 and 10,000 babies a year.

I worked in Kimberley (in the north-west of West Australia) on three occasions. During the telephone interview I was asked if at my age I could manage getting in and out of small planes. The tyranny of distance and isolation soon became very obvious. I moved from hospital to hospital three times in 2 weeks. The working time lost was such that for every 2 to 3 days of work, 2 days were allocated for travel. In one unusual assignment, I was to fly to Balgo to work for 1 day. If you have not heard of Balgo, do not be concerned – most Australians share your blissful ignorance! Without using any modern navigational aid, my crude way of locating Balgo goes like this: if you put a pin in the middle of the map of Australia and move it about 1000 km westwards, you will be at Balgo, where 16 aboriginal families live. That’s it! I spent an hour waiting for the patients because the nurse had to collect them from their homes. Most of the six patients had either forgotten their problem or their problem no longer bothered them. The patients had to travel a 6-hour round trip for this! The tourist element in all this was that we had to fly past the Wolfe Creek meteorite crater and the pilot kindly took the plane to a lower level so that I could have a good look. This crater measures 880 m
wide and was caused some 300 000 years ago by a meteorite weighing more than 50 000 tons, which was thought to be travelling at about 15 km/sec-
ond. This speed would have taken it across the continent of Australia, east to west, in 5 minutes.

From the beginning I de-
cided that I would not commit to working in any hospital I had not previously worked in for more than 2 weeks. That was so that if I did not like the place, the hospital or the staff, I would be flying out before the situation got too awk-
ward. This rule was broken at Townsville Hospital in the north of Queensland, where there is a good system by which the local staff string their leave together so that a locum can be engaged for 6 to 12 weeks at a time. My first stint at Townsville Hospital was for 8 weeks and I have been back more than six times, to-
talling more than 50 weeks. I love the work, the people and the place, mostly because the folks are friendly and I get to go fishing on a regular basis.

In one small hospital I was expected to resuscitate a baby. I protested, only to be told that there was no paediatrician in town! Fortunately, I trained in the days when the ac-
coucheur was also the ‘neonatologist’ in the labour ward, so I can still manage to put an endotracheal tube down. There-
after, the neonate had to be moved out to a tertiary centre.

Another interesting job was a call for help from the Fiji School of Medicine through the Royal Australian and New Zealand College of Obstetricians and Gynaecologists. I had read an article in Time magazine about a woman dying in childbirth every minute worldwide. That same week I put my hand up and sent in my CV. To convince them I was not decrepit, the next day I sent in a recent video clip of myself doing a tandem sky-dive. Of special note was that my obste-
trician daughter, Dr Sabrina Kuah, was also able to come along for part of the time on a voluntary basis. Suffice to say that the clinical work was most interesting and educational. The hospital was budget-conscious and much of what is taken for granted by us in the better resourced countries was either restricted or not available. The only cardiotocograph machine had to be shared by some three to ten labouring women and the situation got too awk-
ward. This rule was broken at Townsville Hospital in the north of Queensland, where there is a good system by

The folks were very friendly and the pa-
patients grateful to a fault. The students and trainees were extremely keen and it was a pleasure to teach them. This was also the first time my daughter and I had worked together as specialists in the same hospital. It was so enjoyable and interesting that we could not resist an invitation to return. The head of ob-
istaniatrics and gynaecology did confess that when he saw my CV and noted my age, he wondered if the Fiji School of Medi-
cine was making a mistake. Having associated with me for 4 weeks, he was happy to have me back. In addition to our work, we also took 500 pieces of stainless steel single-use surgical instruments and some surgical sutures to the hospital.

All the jobs include the provision of married accommoda-
tion, which is an important factor to my wife (who retired from teaching English 45 years ago) and I. In her retirement, and in the absence of any grandmother’s duties, my wife travels with me each time. She enjoys cooking and baking, often sending cakes and curry puffs to the hospital staff. The quality of the accommodation varies widely. For instance, I am writing this sitting in the cozy lounge of a lovely, com-
fortable, almost luxurious three-bedroom apartment looking out at the shimmering water in the river mouth, caused by the reflection of the lights. On the other end of the scale, one hospital put us up in a tertiary students’ hostel, while elsewhere we have stayed in holiday parks, an inflated name for an upmarket caravan park.

Of course, there is a lot of flying from place to place and we frequently have three sets of air tickets in hand. Currently, I have seven sets of air tickets to be used before the end of the year. I do not believe this travel schedule myself! Not even in my wildest dreams would I have imagined that I would end up doing this sort of frequent travel. Often we will spend only 15 to 30 hours at home in between jobs. Interestingly, 4 years ago our grand-daughter complained that we were ‘taking too many holidays’!

Moving from hospital to hospital and working in diverse environments calls for special attributes and attitudes. The doctors are different, the mid-
wives and nurses are different and even some of the patients may be different. There is no place for dogmatism and some flexibility does not go astray. One has to be a little pli-
able and compromising to fit into the working environment of the day.
to the hospital. In another scenario, I walked out of my consultation room in the midst of a clinic. The nurse in charge stopped me and loudly asked where I was going. Quick thinking had words out of my mouth, just as loudly, before she had finished, asking ‘Do you want to come along? I need to have a leak!’ She never questioned my movements again.

In the last few years, the fact that I have not been engaged by any hospital where I am not known would suggest my vintage is raising a little hesitation. However, I now feel healthy and fit for my age. This is because in the last 10 years I have decided to care for my health in addition to the health of the women I look after. However, it is not possible for strangers to take this statement as gospel truth; one registrar in Fiji said to me, ‘We have been discussing, and we are amazed that your hands do not have tremors when you operate!’

I am now in my 76th year of life. Not many of my peers are still actively working. I remember when I was lecturing at Oxford my then chief, Professor Chassar Moir, retired in his early 70s and was doing a little private work. I asked myself why he was working instead of resting on his laurels. Now I fully understand that he was enjoying life, as I am now.

Photograph competition: ‘What makes my workplace special/different?’

Membership Matters is holding a photographic competition with the theme ‘What makes my workplace special/different?’ Every working day all of our membership have experiences that make their work special. We are looking for those who are able to capture a feature of their workplace which sets it aside from others: perhaps it is the view inside or outside your workplace, or maybe the building itself.

The competition is open to all Fellows, Members and Trainees with a prize of a £30 voucher to spend in the RCOG Bookshop. Please submit your photographs by email to the Head of Corporate Affairs, Luke Stevens-Burt: lstevens-burt@rcog.org.uk. The best photograph will be printed in the autumn issue of Membership Matters. The closing date is 31 August 2011.

Photographs should be a minimum of 300 dpi. Any images of people must comply with UK data protection law: go to http://www.rcog.org.uk/what-we-do/publishing/author-information/data-protection for more information.
that, owing to grants running out in 2011, the unit may be forced to close.

The team also visited the maternity unit of the University Hospital. Although the effects of the earthquake were evident, the maternity portion of the hospital was fully functional. Concern was expressed over patient numbers declining as a result of an NGO which opened in the vicinity offering free care and undermining local facilities.

We then went on to provide local training. Our trainees were respectful and polite but very sceptical (‘wealthy do-gooder Americans and Brits coming to tell us what we should be doing’). They also expressed their extreme frustration with NGOs. The provision of free services by NGOs had disrupted both physician practices and hospital management. Physicians have left Haiti because of their inability to financially survive and hospitals have closed. There was earnest concern that when these NGOs eventually leave (and some had already left), the medical system might actually be worse rather than better.

The major teaching activity involved the delivery of a mini-MOET course led by Felicity (an obstetric anaesthetist from the UK) and me. The programme included lectures, manikin exercises, videos and scenarios. The interactive teaching practices were popular, with the discovery of much local thespian talent, and despite language difficulties the message seemed to get across. The Haitian doctors and midwives were good-humoured, highly intelligent and tolerant of our lack of French and Creole. The obstetric manikins generously donated by Wellbeing of Women were given to the midwifery school for continuing training.

We were accommodated in a safe house. We knew it was safe because we had two guards with AK-47s on the door! The possible downside, for Felicity anyway, was that the four of us slept in the same room. The compensation was a small swimming pool and the facility for a safe early-morning run.

We also shared with a couple of International Medical Corps personnel and one ex-
French Foreign Legion security advisor who informed/scared us with reports on the occasional untoward events befalling visitors. However, we travelled with no security and, despite driving through dark narrow streets at night, we never really felt threatened.

The purpose of the trip was two-fold: first, to make contact with the doctors who will be providing long-term care in Haiti, provide some low-key interactive teaching and learn from the Haitians the problems they face; and second, to get some idea of the devastation caused by the earthquake and the pre-existing medical problems and to build further links.

The philosophy of the International Medical Corps, who made the trip possible, is to give local people the tools and knowledge to help themselves so that the investment can sustain development beyond an existing crisis; this is achieved by working with governmental and official organisations and building long-term, sustainable relations. We therefore greatly look forward to returning, although sadly at the time of writing the political situation has not stabilised and reconstruction is progressing slowly.

We were made very welcome during our stay; Dr Roger Jean-Charles was an outstanding host. Special thanks go to Naomi Gikonyo for her successful efforts to bring the conference together and make our stay productive, enjoyable and memorable. The team is looking forward to a follow-up visit.

Thanks also go to Professor Marty Olsen, who co-wrote this report, and Dr Randall Williams and Dr Felicity Plaat, who were part of the team.

Professor Charles Rodeck FRCOG

Professor Charles Rodeck received the Eardley Holland Medal in September 2010. His achievements in women’s health are numerous and he has been an inspiration to many of his peers and those who have trained under him. Here he takes time out of his schedule to give us a few insights into his life.

Could you tell us about your background and where you grew up and trained in medicine?

Well, I was born in Czechoslovakia in 1944. My parents were of German origin and Czechoslovakia had a large German-speaking minority: about one-third of the population. After the war, they were all expelled. I came to England in 1949 and received all my education here. I went to University College London to train in medicine and qualified at the end of 1969.

What attracted you to that particular university?

Its reputation, I would say, and its tradition of being radical and open. It was the first university in England to admit people of any race or creed as well as women. It was a very progressive institution, and still is. It also had a very good biomedical sciences set-up and offered more BSc degrees than other medical schools at that time.

Do you think those things fitted in with your ethos and your ideas of study?

In a way, yes. I probably wasn’t very conscious of it at the time, but the interview went well and when they asked whether I particularly minded where I did medicine, I said, ‘Not really, I just want to get started’.
What attracted you most to a career in the medical profession?
It started off with being interested in animals as a child. I wanted to be a vet, but then I thought, well, what is the point in being a vet when you can be a doctor and treat humans – no disrespect to vets, of course! Quite late in my school career, I started sciences and I was a bit surprised that I found biology so interesting. I think it is very important to be interested in the subject. The fact that medicine gave you the security of a profession while at the same time you were doing good, or supposedly doing good, were helpful add-ons.

So were biology lessons your first exposure to the medical world?
I think so. Also, what was quite inspiring was that in the late 1950s or early 1960s there were a few BBC television programmes on biological sciences which showed the work of Crick and Watson on the structure of the DNA double helix, X-ray crystallography and Perutz’s work on the molecular structure of haemoglobin (presented by Raymond Baxter).

What did you enjoy most about your early training?
There was a time when every subject I went through and every attachment I went to really seemed interesting. I was certainly interested in neonatology and genetics, such as it was then. In fact, I also did a spell in neuropathology, which I enjoyed and nearly got diverted into. I think I was always interested in how things got to where they are; that is, in development. So, among the medical sciences I found embryology fascinating, and clinically it wasn’t a huge step to obstetrics. Certainly, the first time I saw a baby being born was a most dramatic moment for me and had a tremendous impact, confirming that it was what I wanted to be involved in.

If you weren’t in this specialty, what do you think you would be doing right now?
Maybe genetics. Despite major advances and developments in genetics coming later, I think it would have been very rewarding to be involved in the early stages as well. Non-medically, I think I might have chosen history or archaeology – again trying to understand how things got to the state they are in.

What do you think is the most interesting period of history?
There are quite a few really. It must have been amazing to be alive in 5th century BC Athens or the Renaissance. Each age gives you another set of explanations as to why things have happened. I think the terrible 20th century and what happened then is very important, and you could argue that it is the most important era as it is closest to us.

What is your proudest achievement?
I think it has to be receiving the Eardley Holland Medal because it represents recognition by one’s profession and peers. One of the things in medicine is that you get job satisfaction quite quickly and frequently. Being up all night with a difficult labour and having a healthy mother and baby gives you a tremendous feeling. Research is rather the opposite. Sometimes you have to wait for years before you get any job satisfaction there.

Have you had any experiences outside of medicine which you find useful in your medical career?
That is a difficult one. I think it is quite possible that, having been an immigrant myself, I’ve been sympathetic to other immigrants, both patients and doctors. I have always enjoyed greatly having visiting doctors from abroad in the department and have always been sympathetic to them.

Those are very useful things to have brought with you – understanding and empathy. What was one of the most difficult experiences you’ve had to deal with and what have you learned from it?
That is also a difficult one! I think it was probably a medico-legal case about a fetal malformation. I scanned the mother, but I didn’t discover it. It came back a long time afterwards and went to trial, which was a horrible experience. We won – the trial judge gave for us – but then it went to appeal, which we lost. I guess I learned that no matter what you are doing, it does not always reflect what the world or others might think.

Now for some personal questions about the man himself and what goes on behind the scenes. When you are not working, what do you enjoy doing?
Mainly reading and listening to music, both on CD and live. My wife and I like attending concerts and operas and particularly going to music festivals. A project of mine is to get around all the major opera houses in Europe. We go to the theatre and galleries and go hill walking in Scotland, where our daughter lives, a couple of times a year. In the last 10 years or so, I have been going to football matches with my son at Tottenham Hotspur, who are doing very well at the moment, for a change!

Any predictions for the end of the season?
Well, I think if they get into the top four again that would be good.

If you could bring back one person from history and ask them one question, who would it be and what would you ask them?
I would like to – somehow – ask Beethoven how he coped with his deafness. His hearing got worse and worse so he had to stop performing and conducting. But he was so embarrassed that a man in his profession, above all, should be deaf. I think, in those days, there wasn’t quite the tolerance that we have for disabilities and so it was a tremendous blow. Towards the end of his life he was totally deaf and retreated to an inner world.
If you were holding a dinner party, what would be on the menu and who would you invite? Your guests can be people from the past as well, so Beethoven could be on the list. Well, I think Beethoven would be difficult to have a conversation with! So no, I would like to get round the table Hitler, Stalin, Alexander the Great and Jesus Christ. I would like to understand what motivates these dictators, conquerors and mass killers and how they can reconcile their own lives with such crimes. It would be really fascinating to seat them with, let’s say, a Christ-like figure and speak to them about ‘love thy enemy’. I have no idea about menu. Maybe Christ could read the Sermon on the Mount and give them five loaves and two fishes!

If you were a super-hero, what super-power would you have? I would like to enforce tolerance! Being intolerant seems to be so inbuilt into the hypothalamus and it is so destructive. I think it is a bigger danger to mankind than global warming, pollution, etc., which are potentially all fixable by technical means or political action. It is much more difficult to try and stop the hatred. If that could be eliminated from the brain somehow, without any other side effects, that would be very beneficial.

What was the last book you read? Jared Diamond’s Guns, Germs and Steel. I bought it over 10 years ago and it has been on a pile – I have many large piles of books waiting to be read! It is a fascinating book about early mankind and why some societies have developed the way they have, why some more than others, and why civilisations rise and fall. It was a really very good read.

Do you have any pet hates? The cult of celebrity. It gives people the wrong priorities and is very damaging.

Do you have any ways you like to de-stress? Well, I think the best thing is to try not to get stressed. Obviously, when you are in a busy job, you do get stressed. But by and large, if you enjoy what you are doing, stress is not a bad thing, and in fact physiologically the stress response is vital. I think doing something you enjoy is good. It could be listening to the news or reading something or going out for a good meal and a bottle of wine. I have two British Blue pedigree cats and they are very therapeutic. Actually, having a cat sitting on your lap is good way of de-stressing!

Any particular favourite wine? Many! There are so many good wines being produced, both red and white. Also, a dram of whisky is very welcome! It’s a wonderful invention that the Scots have given the world.

Are there any favourite destinations you have been to? One of the problems with going to conferences is that it really prevents you from seeing the things you might want to see there, but one trip stands out. I think it was the first time I went to India, to talk at a postgraduate programme run by the Taj Hotels. Surprisingly enough, they had a postgraduate medical education department and they then funded a sightseeing trip around major sights in India, staying in Taj Hotels. That was absolutely wonderful. India is a wonderful country. It has got huge problems, but they now seem to be dealing with some of them in a reasonably successful way.

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RCoG Fellow is President of Universities UK

The College would to congratulate Professor Eric Thomas on his recent appointment as President of Universities UK, the representative body of all Vice Chancellors and universities. The recognition and admittance of one of our membership at this level is an exceptional reflection on the ability and personalities of those in our discipline. We wish him well in his post, which finishes in 2013.

Achievements and awards

Because Membership Matters will be more member focused than RCOG News, we hope that you will take an active interest by sharing stories of noteworthy achievements or awards received. If you have been recognised at any point during the year and have not informed the College, please let us know so that we can publish a snippet in Membership Matters. Please submit your achievement by email to the Head of Corporate Affairs, Luke Stevens-Burt: lstevens-burt@rcog.org.uk.
Trainees need leadership

TED ADAMS CHAIR, TRAINEE’S COMMITTEE

We are entering another new phase of change in training, although it has familiar ingredients: the European Working Time Regulations, a change in government policy and impending NHS financial meltdown.

These issues are already affecting our training and also the jobs that we take as new consultants. We are going to need strong leadership to help us protect the quality of our training and the time which we have to train. This leadership will be needed at all levels. The College will be important at a national level and deaneries will play their part, but I think consultants at trust level and their influence with individual trainees and trust management will be the most important issues.

In 2002, the then Chief Medical Officer described the senior house officer grade as ‘the lost tribe’. I am concerned that, despite the changes made in training, all trainees are becoming members of that tribe. That is not to say curricula or ways of measuring training are poor – indeed, we have made real progress in the last few years – but rather that trainees in their general working lives feel a bit lost.

We have lost teams and some consultants do not have registrars and senior house officer level doctors assigned to them – something that will occur more often as the number of consultants increases and the number of trainees decreases – so the link between individual senior and junior doctors is sometimes precarious. With that precarious link comes uncertainty and concern about both clinical and non-clinical matters. This contributes to junior trainees complaining that they do not receive career guidance and senior trainees worrying that they cannot get certain things signed off in their portfolios.

We bemoan the above changes, but have we come up with any ways of dealing with them? All trainees have an educational supervisor, but sometimes that supervisor does not provide all the clinical supervision for a particular trainee. However, it is not just clinical supervision that is important: other factors are important too. Pastoral care is the general catch-all term, but there is more to it than that: learning how to talk to patients, learning how to deal with colleagues and providing role models (good and bad) are important parts of our craft that we are missing out on.

Perhaps the change to GP-led commissioning will provide us with an opportunity to take up the leadership challenge. The establishment of the National Leadership Council has focused attention on leadership, while the issue of clinical leadership has been a higher priority since Lord Darzi’s report. From the trainee’s perspective, the curriculum includes a great deal of the medical leadership competency framework, so there is an expectation that trainees will learn about leadership too.

I have recently finished a year as a leadership fellow at NHS North West, where I had the opportunity to learn about leadership theory and what makes a good (and bad) leader. Being a leader is not always easy, particularly when there are competing demands on your time and resources, but my experiences made it clear that where strong leadership exists – and NHS North West itself was fortunate enough to have a very good leader in Mike Farrar – people responded well to it.

I am looking forward to my term as Chair of the RCOG Trainees’ Committee and will do my best to provide the trainee view when asked; it is possible that I might provide it even when it is not asked for! I also need to provide leadership to the committee and to trainees across the UK, which I hope can be complemented with leadership at a local level from regional trainee committees and, most importantly, from consultants to their trainees.
Training our colleagues of the future

DR CLAIRE MCKENZIE MRCOG
CHAIR, SPECIALTY EDUCATION ADVISORY COMMITTEE

In the UK, medical training has gone through significant changes over the last few years with regulation for training moving from the Royal Colleges to the Postgraduate Medical Education and Training Board and now the General Medical Council. This has necessitated a review of the way in which we train our future consultants.

For most trainees, training commences immediately following foundation training. Annual progress is monitored and managed by the deaneries through the annual review of competence progression. It is vital that trainees are adequately assessed through this process to ensure standards are met. Progression through training is assessed through the evidence that the trainee collects and records; this includes clinical and non-clinical training achievements (audits, research, guideline development) and the educational supervisor’s report. The RCOG is developing guidance, in conjunction with the Heads of Schools, which will establish the annual targets that need to be achieved, both clinical and non-clinical. This guidance will be available in 2011 and be called the Matrix for Educational Progression.

A major change to the curriculum has been to address the final years of training through the introduction of the Advanced Training Skills Modules (ATSMs), which the majority of trainees will undertake. It was recognised that the original ATSMs needed revision to match the roles that consultants undertake, so the major gynaecological and obstetric ATSMs have undergone edits to ensure that they reflect the clinical responsibilities of consultants. The modules have been developed with the specialist societies and will be available on the RCOG Education pages in 2011 (http://www.rcog.org.uk/education-and-exams/curriculum/advanced-training-skills).

Alongside the introduction of the new ATSMs, more specific career advice has been developed for trainees, who must make decisions before registering for the ATSMs. The ATSMs have been given a work intensity score of 1 or 2, which reflects the amount of time that the individual ATSM will require to be undertaken. Trainees will be advised that they should undertake ATSMs whose work intensity scores total no more than 3. Trainees will have to focus to choose the most applicable ATSMs for their skills.

Subspeciality training is an alternative route for the final 2 years of training and leads to a specific set of skills. It has been recognised, through the work undertaken to produce The Future Workforce in Obstetrics and Gynaecology, England and Wales, that there are too many subspecialists being trained for the anticipated vacancies. With this in mind, a review of the curriculum and guidance for training centre recognition is being developed jointly between the specialist societies and the RCOG. This review and guidance are anticipated to be available in 2011. Some training centres may choose to become ATSM training centres instead.

Ultrasound scanning has gained an increasing role in the management of our patients and the RCOG recognises the need to develop these skills in our future consultants; however, it is also recognised that not all trainees will require or have the ability to gain advanced ultrasound skills. There are two basic and three intermediate ultrasound skills modules which detail the skills expected. All trainees must acquire the skills of the two basic ultrasound modules as part of their training. It is recognised that the introduction of the ultrasound scanning modules has presented a significant challenge in delivering training, but continuing liaison with ultrasonographers should be encouraged to help facilitate this.

In 2010, the General Medical Council asked all Colleges to integrate three new frameworks into the curriculum: a common competency framework, a medical leadership framework and health inequality framework competences. The aim is to produce leaders for the future. To make the curriculum manageable, the RCOG has colour-coded the new additions. The RCOG remains alert to the fact that clinical practice undergoes continual development and, as such, the curriculum must be seen as a living document that reflects practice and hence can be changed as necessary. We welcome feedback on any aspects through curriculum@rcog.org.uk.

The full implementation of the European Working Time Regulations has had an impact upon the amount of day-time supervised training of our trainees. The number of vacancies within rotas additionally has a negative effect. It is essential that, rather than seeing the training programme as time based, trainers remain focused upon ensuring trainees are competent to progress from level to level. Equally, when progress is slow, constructive feedback should be provided and perhaps also intensive targeted training if necessary. Ultimately, we train our future colleagues and it is imperative that we do this well for the benefit of both trainees and patients.

To help define the roles of trainers, the RCOG has produced a Handbook for Trainers, which also provides practical advice.
The voices of the future: ‘Peaches from bitter almonds’

PETER WILSON ST1, MERSEY DEANERY

This essay is the winner of a new prize offered by the College, ‘Why Obs and Gynaec?’, an essay competition aimed at junior doctors who have chosen a career in the specialty.

Shoes are polished as we refer to the enticing balance of medicine and surgery and testify to the benefits of a field which proffers both acute and chronic work. Shirts are ironed with cautious gusto as we refer to the rewarding nature of a rapidly evolving specialty which involves both research and teaching opportunities. This is all quite true and laudable. However, there are two reasons which are thought by many but spoken by few. Firstly, I am convinced that a sizeable proportion of us entered this profession through an inconvenient desire to do a little good. Secondly, our decisions are inevitably based upon experience, which is often a far more powerful persuader than an interview-friendly reason. The single most important factor in the enjoyment of a rotation for any junior doctor is undeniably the character of one’s colleagues – who are more often than not also one’s seniors.

As applicants all of us know that it would be foolhardy to let one inspiring consultant colour our view of a specialty in which we are highly unlikely to encounter that particular doctor again. Yet, perhaps this consultant has shown us the character of the doctor we want to be and this image is troubling to separate from the field in which it is grounded. I must hold up my hands and confess that I chose to train in obs and gynaec because of a mentor who backed me and made me want to be better. We are a product of our teachers more than we are allowed to give credit for. As American writer William Arthur Ward once wrote, ‘The mediocre teacher tells. The good teacher explains. The superior teacher demonstrates. The great teacher inspires.’

Another reason as to why I value a mentor in obs and gynaec so highly is due to it being an inherently practical subject. For a trainee to take the step of becoming involved in new and potentially risky procedures requires the assurance that your consultant is behind you – both physically and metaphorically. The second reason as to why a solid backer is so important is that there are no two ways about it: on occasions, obs and gynaec may seem like the proverbial minefield. Rosa Prince writing in The Telegraph in December 2009 commented that obs and gynaec cases account for nearly half the compensation paid by the NHS Litigation Authority. That said, I have never viewed this as a reason to steer clear of the subject, but have seen it as testament to the importance of our work. Claims are potentially so high because the decisions and actions of obstetricians and gynaecologists can have such profound and far-reaching consequences. This is not a reason to shy away from the subject, but a reason to get involved with the knowledge that what we are doing is so fundamentally important and worthy. As John Powell (a contemporary American writer) observes, ‘the only real mistake is the one from which we learn nothing’.

Whilst an inspirational consultant undoubtedly played a significant role in my enjoyment of the subject, there are of course facets of obs and gynaec itself which sparked an interest. One of these aspects was the fascinatingly eponymous nature of the specialty. Amongst many, there is Vivian Bartley Green-Armytage, whose haemostatic forceps are still used widely the world over. Mentioned on three occasions in dispatches during the First World War for gallantry, he was also said to often evoke applause from sizeable crowds in his operating theatres. I have no doubt there are just as many colourful and brilliant characters practising obs and gynaec today and as such I feel honoured to be joining their ranks.

So what is obs and gynaec’s ‘unique selling point’? It is the magnificent wonder of new life, not ceasing to amaze, over and over – much of the process yet to be explained despite our bright lights and beeps. Perhaps particularly special to a tired obstetrician as it is often accompanied by a tidal wave of relief. And what is more, I have witnessed smiles on the lips of even the most cynical of doctors, who are joining in with the delight and surprise of very new parents.

It was Mark Twain in his novel Pudd’nhead Wilson who wrote, ‘Training is everything. The peach was once a bitter almond…’. When I researched obs and gynaec I was very encouraged to discover a carefully laid out and highly structured training programme. Each year of the ST programme has a well defined set of aims and expected competencies. Hard things are much easier to achieve if you are clear about exactly what it is you are trying to achieve.

I am a geek and therefore am delighted by the numerous technical advances and refinements in surgical techniques which have been so prominent in obs and gynaec in recent years. But I was also driven towards the specialty by the potential for work in the developing world. Here there is scope to improve women’s health through the wider provision of services which are in some cases sufficiently basic to be considered a human right in the developed world. What is more, as Sarris et al. comment, ‘Still, for too many women in the world, biology truly is destiny and can be tragic… Many of women’s gains in modern society rest on control and containment of their obstetric and gynaecological health.’ Not only does this re-affirm the importance of our specialty for women, it hints at some of the slightly more removed potential benefits our field has to offer in the developing world.

In the final analysis, my goal is to become a competent obstetrician and gynaecologist. Nothing more and nothing less. For this to be considered of me will be reward enough.

Reference

Accepting the fact that it is generally better to offer more conservative treatments to women as an alternative to hysterectomy in the first instance, in accordance with National Institute for Health and Clinical Excellence guidelines, and that the only real indication necessitating total abdominal hysterectomy is uterine size greater than about 18 weeks, the vast majority of hysterectomies should be minimally invasive. This raises the question of which technique to use. Vaginal hysterectomy has been shown to be a successful minimally invasive approach if the surgeon is experienced and well trained, including in women who have relative contraindications to vaginal hysterectomy such as nulliparity, previous caesarean section, requirement for oophorectomy and an enlarged uterus. Vaginal hysterectomy fulfils the requirement of having a low complication rate, the potential for reduced length of hospital stay and a low readmission rate that consequently makes it very cost effective. Therefore, it makes sense for the modern gynaecological surgeon to include vaginal hysterectomy in their armamentarium.

Laparoscopically assisted vaginal hysterectomy and total laparoscopic hysterectomy are really extensions of vaginal hysterectomy in the sense that the uterus is delivered in the same way. The only difference is that laparoscopy extends the capability of the surgeon by enhancing their view, making adnexal removal easier and allowing them to deal with other pelvic pathology such as endometriosis and ovarian cysts simultaneously. Alternatively, subtotal laparoscopic hysterectomy is less technically demanding than total laparoscopic hysterectomy but requires the additional complication of morcellation for completion. These laparoscopic techniques are useful not only for hysterectomy but also for the excision of other conditions such as endometriosis and fibroids. Despite its benefits, total laparoscopic

The VALUE study, published in 2002, highlighted the fact that 67% of hysterectomies were still being carried out by open surgery, despite the fact that it is now clearly recognised that less invasive techniques – including vaginal hysterectomy and laparoscopic approaches – result in less pain, reduced hospital stay and faster return to normal activities. The underlying reason for the high rate of open surgery is not likely to be that the surgeon considers open surgery to be the optimal route in 67% of cases, but rather that it is the only procedure that many gynaecologists may be able to offer. Benign gynaecological surgery appears to have been neglected and it still seems that total abdominal hysterectomy is ‘acceptable’ despite there being better techniques available. As a result, women (in the UK at least) are almost certainly not being offered the full range of available treatments and are being ‘short-changed’.

The question is whether or not this is acceptable practice in the 21st century. It seems clear that we should be producing gynaecological surgeons who are independently capable of offering a full range of options from an armamentarium of medical therapies, including treatment of the endometrium and open and minimally invasive hysterectomy techniques. Such a gynaecologist would be able to offer different options to women that more accurately fit with their pathology, social circumstances and wishes. To achieve this aim there is little doubt that we must become more subspecialised; training programmes are required to reflect this. The development of the 2-year Advanced Training Skills Module (ATSM) ‘fellowship’ in benign gynaecological surgery and the possible amalgamation of certain benign gynaecological surgery ATSMs to produce trainees with a wider range of abilities are welcome developments.

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hysterectomy was used in only 3% of cases in the VALUE study. The reason for this is multifactorial: much of the early data showed increased complications, the technique appeared to be expensive and, more importantly, the technique appeared to be difficult to learn. The first two factors have been largely rebufed as techniques and equipment have developed. Large case series now show very low complication rates. The last factor regarding training is the most important, as the skills required to carry out advanced laparoscopic surgery are not easily attainable. Many gynaecologists have managed to achieve an ‘intermediate’ level that allows them to tackle ovarian cysts and ectopic pregnancies, but the number of gynaecologists routinely carrying out and exploiting the benefits of laparoscopy are limited. The explanation is likely two-fold: first, gynaecologists are not as immersed in operating as their surgical colleagues; and second, not everyone is capable of overcoming the spatial awareness problems, instrument counterintuitiveness and unstable platform that are features of conventional laparoscopy.

Robotic surgery first began to be used in gynaecology in the USA in 1999. By 2009, the rate of prostatectomy, which is similar to hysterectomy, performed robotically had risen to 90%. The explanation for the uptake of robotic technology is that it has become easier to learn, the spatial awareness issues have been addressed, platform movements have become more stable and the ergonomics for the surgeon have been improved.

So, the point of this is not whether patient outcomes with robotics are better than with conventional laparoscopy, as a skilled laparoscopist will attain very high levels of quality with low complication rates regardless of the technique used. To reveal the potential advantages of improved robotic view, precision and ergonomics, the power calculation required for any study comparing conventional and robotic laparoscopy would require sample sizes beyond the scope of surgical trials. Instead, the point of robotics is that many more gynaecologists will be able to achieve advanced standards of minimally invasive surgery and so fulfil the expectations of a true 21st century gynaecological surgeon, whether for benign hysterectomy or for more complex benign and oncological indications.

The National Patient Safety Agency (NPSA) has issued a World Health Organization (WHO) surgical safety checklist for maternity cases. The development of this checklist was a collaborative project between the NPSA and the Royal College of General Practitioners in response to requests from maternity services. It can be downloaded from http://www.nrls.npsa.nhs.uk/resources/clinical-specialty/surgery/?entryid45=83972.

There is a growing body of research demonstrating the impact of the use of checklists in the surgical pathway on patient outcomes and on teamwork and communication. The NPSA has led on the implementation of the WHO surgical safety checklist in England and Wales, issuing a patient safety alert requiring NHS organisations to implement the checklist for every patient undergoing a surgical procedure. Feedback about the implementation of the checklist in England indicates that commitment from clinical staff is an important factor in promoting team communication and reducing the likelihood of the checklist becoming a tick-box exercise. Staff at sites that piloted the checklist adapted for use in maternity cases also commented on the importance of motivation and of good communication between theatre staff and medical staff and midwives.

The final version of the NPSA checklist for use in maternity cases was agreed by a multidisciplinary project group following an evaluation of the pilot of a draft checklist at nine sites in England and Wales. This checklist is for women having caesarean sections and other procedures related to childbirth (for example, manual removal of the placenta).

Some of the checklist items, in particular those undertaken by the midwife, will not be required for procedures other than operative delivery. Local adaptation of this checklist is encouraged to ensure it is effectively integrated into clinical practice (and a Word version is provided for this purpose). It is recommended that any adaptations should be implemented using improvement methodologies such as plan, do, study, act cycles.

References

International update

PROFESSOR JAMES J WALKER SENIOR VICE PRESIDENT (INTERNATIONAL)

This is an exciting time to be Senior Vice President (International). The maternity agenda is high on the list of international health priorities and we at the RCOG can contribute hugely to this. It has been a very fast-moving 4 months and the tempo will increase further in the coming year. It is an honour to be part of these developments. I thank all those who are contributing so much to the success of our efforts.

International courses

The International Office, in conjunction with the Liverpool School of Tropical Medicine, now runs successful courses in life-saving skills in 12 different countries. In the future, we would like to build on this success by developing other courses linked to education and training which are well established within the RCOG, as well as developing new themes where there is a need. We require a larger trained faculty to achieve this and we hope that, with the help of our Fellows and Members, we can achieve this aim.

International fellowships

In conjunction with the Brody Trust, we have successfully run a fellowship programme in Uganda for trainees. The RCOG is looking at ways to expand and vary these fellowships, which are an opportunity for UK registrars (usually post-MRCOG) to take time out of formal service training for a period of intensive clinical and leadership work and training in a different country. By sharing their skills, knowledge and best practice with local colleagues in the developing world, those undertaking the fellowships will help to tackle the crippling human resource shortage currently affecting many developing countries. In addition, UK-trained doctors and the NHS will gain unique clinical experience and leadership skills that will benefit them and the greater NHS. We are developing an Advanced Training Skills Module to complement this experience.

We are looking to develop these opportunities as recognised out-of-programme experiences. The College has raised this issue with the Postgraduate Deans and, along with the Conference of Postgraduate Medical Deans of the United Kingdom, we will be discussing this proposal with the General Medical Council in the hope that by working together we can resolve issues as they arise and wholeheartedly support those who decide to participate.

Capacity building

As a further development of our global programme, the RCOG International Office has decided to focus on a region in one country – Uganda – as a model to increase capacity, training and education. In collaboration with local administration and obstetrics and gynaecology representatives, we are developing a programme to look for the appropriate funding along with other non-governmental organisation partners. This will build on the current training and fellowship programme but bring in sustainable capacity building and outcome assessments.

Advocacy

As a driver for all these changes, the Advocacy Sub-Group is working to increase the College’s involvement in women’s health globally. We need to have a presence around the table to be able to offer the skills and resources we have. Over the last 6 months we have built liaisons with various organisations and are now seen as an advocate for women’s health worldwide.
Even by its normal standards, the European Board and College of Obstetrics and Gynaecology (EBCOG) has had a busy year. I am delighted that many proposals about important issues that had been raised throughout 2010 were agreed in principle at our Council meeting.

One of the decisions that Council made was to replace the position of Vice-President with that of President-Elect. This will require a change to the Constitution, so a formal vote on this motion will be taken at the next Council meeting in London (May 2011). The mandate periods of all the Officers will remain 3 years, but our intention is that the introduction of the position of President-Elect will ensure more continuity. If the change is agreed, this position will come into effect at the end of my term of office. We have also developed job descriptions for all the Officers to help to clarify their roles and remits. The European Union of Medical Specialists (UEMS) has also been having a debate on its mandate periods. At its recent Council meeting in Prague, it decided to move to 4-year terms of Office with the possibility of one subsequent re-election for all posts.

The last UEMS Council meeting was a landmark for the UEMS Boards, which were invited to attend for the first time. UEMS is an umbrella organisation representing all of the medical specialties in Europe. To date, the UEMS Council has consisted mainly of representatives of national medical associations, while the specialties themselves have not been involved. Thanks largely to the efforts of the Past President, Professor Bill Dunlop, this situation has now been rectified and the specialties are fully represented on the UEMS Council.

The EBCOG website (www.ebcog.eu) has undergone some changes and I would urge you to visit us there and see our new-look site. Not only does it look different, there is now so much more information available. The site has different levels of access and you will need to register to access it. We are considering having a forum on the site to make it more interactive and also including e-learning materials, which you will be able to download and use as a resource. The Chair of our Working Party on E-Learning, Professor Juha Mäkinen, is currently surveying e-learning resources across the EU. The most recent EBCOG documents are available on the homepage and the European and national society news sections will become much more prominent.

EBCOG is continuing in its efforts to develop closer contacts with the European institutions. The good news is that in January 2012 we will meet with members of the European Parliament’s Public Health Committee. The focus of the meeting at the European Parliament will be on standards of care, as this is an area we are keen to see addressed at European level. It is one of EBCOG’s current focuses and a working group, under the chairmanship of Dr Tahir Mahmood, has now been set up to explore how some common European standards might be defined. Standards of care are crucial in assessing variation in care, in preventing inappropriate care and in providing a mechanism to monitor and compare the quality of care. Our intention is to discuss this project with the Members of the European Parliament and ask them to support us in developing European standards which can eventually be used by any medical specialty.

Another issue discussed by Council was that of clinical studies groups. The President of the RCOG has pointed out that in some countries, clinical studies are entirely funded by the departments of health and consequently research structures are subject to certain national agendas. Various international structures, including one in obstetrics and gynaecology, are evolving fast in the UK. The RCOG is looking at how this might be linked to a European structure and whether or not EBCOG could have a role in these developments. Council agreed that this was an interesting proposition and Professor Allan Templeton agreed to chair a working group to look at the feasibility of the idea.

The remit of the Standing Committee on Training and Assessment (SCTA) continues to expand, covering surveys on continuing medical education/continuing professional development, training the trainers, revising the specialist and subspecialist log books, surgical skills and clinical research methodology – and these are just a few of its areas of activity. EBCOG’s SCTA comprises members of EBCOG and also of the subspecialties and special interest groups. Again, a big thank you to all those who have worked so actively in this group, and especially to the Chair of the SCTA, Professor Klaus Vetter, who is also Chair of the Scientific Committee for the European Congress in Tallinn in 2012. Preparations for the Congress are continuing and we hope to see you there on 9–12 May 2012. A preliminary programme and other information will be available in 2011.

EBCOG’s stated aim is to ensure the highest possible standards of health care for the women of Europe and their babies, both now and in the future. However, future standards depend upon high-quality specialist training programmes. We were contacted by two countries during the course of 2010 and asked to support them in convincing their health ministries to retain a minimum 5-year specialist training programme, which we were delighted to do. Please remember that if you have concerns about proposed changes to your training system at a national level, EBCOG is there to help. Do let us know and then we can assess if, and how, we can assist.
The midwifery-led unit is staffed by a dedicated team of midwives, who run the ward without the presence of medical staff. While suffering from shortages of staff and equipment, the ward does not experience the same problems with overcrowding and they have the capacity to transfer women who are developing problems to the main labour ward.

There is a gynaecology theatre suite with two operating tables, but usually there is the capacity to run only one of them. The number of emergency cases on the labour ward means that the elective operating lists for both oncology and benign gynaecology are often cancelled, so women may wait for weeks on end for procedures. Often, the stage of cancer in a woman progresses during this time from being operable to being treatable only on a palliative basis, or a woman will sit in hospital waiting for a hysterectomy for menorrhagia for months, leading to significant loss of earnings.

There is a dedicated urogynaecology theatre with two tables for fistula repair, vaginal surgery and family planning procedures. This theatre suite functions well and has a good record of successful fistula repairs, performing several each week.

Mulago was undoubtedly the most challenging environment I have ever worked in, and the Eleanor Bradley Fellowship was the most rewarding thing I have ever done.

The National Referral and Teaching Hospital in Mulago delivers approximately 33,000 babies per year. In 2009, there were 186 maternal deaths in pregnancy and childbirth. Six to seven percent of the babies delivered either are stillborn or die within a few days of birth. The labour ward handles huge volumes of women every day, with around 60–70 deliveries occurring on the main labour ward daily and a further 20–30 on the midwifery-led unit. The labour ward is staffed by between three and eight midwives per shift.

At any given time, one midwife could be looking after up to 20 high-risk women. There is one operating theatre on the labour ward, and there is usually a queue of women waiting to go to theatre for delivery by emergency caesarean section. The average decision-to-delivery interval is around 7.5 hours, and prioritisation of women is poor. There is a lack of privacy owing to overcrowding and it is difficult to maintain the women’s dignity. The labour ward is dark and difficult to keep clean, resulting in a high risk of infection.
I was lucky enough to have the back-up of a collaborative team in Liverpool, who, together with Mulago, form the Liverpool Mulago Partnership. This charity facilitates knowledge sharing between the two sites through a series of exchange visits between clinical staff. I worked in close collaboration with clinical and administrative staff on the project on two major initiatives: the adaptation of a maternity early warning system for developing settings, and the development of a postnatal high-dependency unit. The latter project started off with a limited budget but, thanks to a significant funding grant from the Tropical Health and Education Trust, it has developed into what will hopefully be a self-sustaining unit.

I gained immense clinical and personal experience during my year at Mulago, gaining exposure to cases that I am unlikely to encounter in the UK. There were times when the job was tough and I wondered whether I was achieving anything, but the highs were some of the best I have encountered in the job. I worked with some inspiring people and forged what I hope will be lasting clinical friendships.

I hope to return to Mulago in the near future, and I thoroughly recommend this sort of work to all trainees.

Perhaps one of the biggest challenges, aside from the conditions at the hospital, was fitting in with the team and understanding differences in culture and practice. This took many weeks and I was still learning at the end of my year. This was crucial when working with colleagues to develop systems and initiatives to tackle the high maternal and neonatal morbidity and mortality rates. We spent time adapting guidelines for the local setting, which posed many challenges that often did not seem obvious at first. Another area on which I focused, and which illustrated many of the barriers to safe maternity care, was the development of a triage system. This system, while seemingly simple, was a lot more complex than anticipated and allowed us to identify problems and pitfalls that were affecting prioritisation of care on such a busy labour ward.

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I hope to return to Mulago in the near future, and I thoroughly recommend this sort of work to all trainees.
So wrote Sir William Fletcher Shaw in December 1938 in his first ‘President’s letter’, continuing a practice which was started in 1935 by the College’s second President, Sir John Shields Fairbairn. The idea had been to circulate a précis of Council meeting minutes to Fellows and Members accompanied by a personal letter from the President commenting on the implications of the more important items on the Council’s agenda. This soon became an established form of communication between the College and its Fellows and Members.

The letter was initially just that: a typed and copied letter from the President addressed to ‘Dear Fellow or Member’ and running down the various points listed in the Council minutes. It quickly became more than a letter and each President had his, or her, own style of writing. By November 1936, Sir Ewen Maclean was writing more of a lengthy newsletter, reporting on College functions and events in addition to issues discussed in Council meetings, including details of Fellows’ admission ceremonies (July 1936) and the complications of dealing with the bequest to the College by its first President, Professor William Blair-Bell (April 1936).

Maclean’s successors unfortunately reverted to the rather dry and matter-of-fact tone of communicating the business of Council, although Dame Hilda Lloyd, President between 1949 and 1952, took the opportunity to appeal to Fellows and Members to loan their silver to the College: ‘may I suggest to those of you who possess any silver tucked away in the family coffers that we at the College would be very happy to display it for you and use it regularly, and so let our Silver Jubilee be memorable.’

In 1952, Sir Arthur Gemmell announced that the printing of the précis of Council minutes was to be discontinued as a matter of economy, with the President’s letter taking over the function of communicating the business of Council. Letters became longer but were still essentially in letter form. Gemmell used its medium to transmit some very important decisions, such as the possibility of moving the College to a site in Portland Place, the re-opening of the College building appeal, the publication of a history of the College by Sir William Fletcher Shaw and the transfer to the College of responsibility for the publication of the *Journal of Obstetrics and Gynaecology of the British Empire* (April 1953).

President’s letters in the following years until 1960 were filled with details of the building appeal, progress on the new building, the opening ceremony and related College functions: the letter had become shorter and less personal. Then came Sir Hector Maclennan, who breathed life into the letter through his infectious eloquence and fervent statements. He used the letter to inform Fellows and Members not only about the issues discussed by Council but also about the structure of the College and the function of committees; details which later would be included in the College annual report, but which at this time were not conveyed so easily to the membership. Maclennan used a more informal and personal tone in his letters, as can be seen in his letter of October 1964: ‘I sit at my desk in this season of mist and mellow fruitfulness to write to you what I think will be a short letter on our recent College activities.’

Moving on, Sir Hector’s successor, Sir John Peel, packed a lot of content into his letters, determined to transmit news about the College, international visits and issues such as the modification of the MRCOG examination and the College’s activity in responding to official reports and papers. By 1971, under the auspices of Sir Norman Jeffcoate, the President’s letter took on a slightly different form, including a new section on research activities.

In his turn, Sir Stanley Clayton once again concentrated on College news, functions and activities, with the difference of acknowledging a long list of unusual gifts to the College, which makes quite fascinating reading. Among the subjects covered in Sir Stanley’s letters was the novel suggestion that a College dinner should include ‘a discotheque’ (October 1974) and support for the statement of the Royal College of Midwives that ‘while male nurses might be given instruction in midwifery as part of a comprehensive course, we consider it inappropriate for a male
nurse to practise midwifery as a permanent full-time occupation’ (December 1974).

With Sir Jack Dewhurst came another eloquent phase in the construction of the President’s letter, dwelling on the long dry summer of 1976, the creation of an independent Australian College and other events at the College, apologetically writing, ‘Lest it should seem that I emphasise wine, women and song too strongly, I must mention a number of scientific events which have been taking place recently...'.

Following the presidency of Sir Anthony Alment, the President’s letter was becoming weighty and more like a newsletter in form, enclosing circulars about College events. So, in 1982, a new booklet form was introduced, divided into three sections covering the UK, international and notices, and still enclosing circulars and covering working party reports, study groups and other events. President Sir Rustam Feroze stated that, ‘This is not in order to “sweep clean” but to help economise on postal charges; it will also take up less space in your waste paper basket...’ The new-look letter was the first to include images, featuring a photograph of Sir Rustam during his visit to India.

The presidential address became shorter over the following years, with more and more of the newsletter taken up with details of College activities in the UK and internationally. By 1993, under Sir Stanley Simmons, the President’s letter had taken a new format once again. It was now a larger A4 booklet, typeset in columns, and including a separate letter from the Senior Vice President and Overseas Officer. This was the direct forerunner of RCOG News, which was launched in February 1994 with a glossy cover, an image of the College building on the front with the full crest and a short presidential address. Four years later, RCOG News helped to launch The Obstetrician & Gynaecologist, which was placed conveniently within the centre pages as an incentive to the membership to dip into the new journal.

The cover of RCOG News has undergone changes since 1994, but has essentially kept the same content. In 2006, Sir Sabaratnam Arulkumaran launched RCOG International News to reflect the creation of the RCOG International Office and to disseminate information on international activities to all Fellows and Members throughout the world.

All of these letters, newsletters and journals are held in the College Archives and provide a fascinating snapshot of the College throughout its 80-year history. It seems fitting to leave you with the wonderful words of Sir Geoffrey Chamberlain: ‘Your College must move with, or preferably a metre or two ahead of, the times. Remember Bob Dylan.'

Left: The first RCOG News was launched in 1994 by Geoffrey Chamberlain

Are you interested in learning more about the heritage collections at the RCOG? Are there some aspects of the history of the College or specialty that you would like to read within these pages? We would love to hear from you and can be contacted at archives@rcog.org.uk or library@rcog.org.uk.

References

1. Archive reference: S21/1, Papers of Morris Datnow as Fellow of the RCOG.

The last ever RCOG News, published in October 2010

The President’s letter soon became an established form of communication between the College and its Fellows and Members
The development of the College brand

LUCY REID | HEAD OF INFORMATION SERVICES
JANE MOODY | HEAD OF PUBLICATIONS

At the beginning of 2011, the College adopted the fresh, new logo and strapline which you will have seen on the cover of this magazine. The aim is to unify the wide range of products and services provided by the College and to present a stronger image to the world at large. But how did the College end up with the insignia with which we are so familiar?

The foundation of the College

From the moment that a college for obstetricians and gynaecologists was conceived, William Blair Bell, one of the founders and the first President, was keen for it to have all the trappings of its existing sisters, the Royal College of Surgeons and the Royal College of Physicians. Blair Bell was adamant that a coat of arms, gowns, declarations and admission ceremonies were necessary to bring the new institution’s Fellows and Members together and to establish its prestige. In his history of the College,1 Sir William Fletcher Shaw, co-founder and past President, describes Blair Bell’s long battle with his colleagues on the first Council to develop the organisation’s image and the strong brand that we now associate with it. In an unpublished draft of this work held in the College Archive,2 Fletcher Shaw admitted that many of his peers considered a coat of arms to be superfluous in the 20th century. It took Blair Bell 4 months and several meetings of Council, the Finance and Executive Committee and the Procedure and Publication Committee to obtain approval for the design work, which was not to cost more than £103 (about £500 today).

Design of the coat of arms

Blair Bell had some initial correspondence, reported in his History of the Origin and Rise of the British College of Obstetricians and Gynaecologists,3 with Omar Ramsden, a celebrated silversmith from whom Blair Bell had previously commissioned pieces for the Gynaecological Visiting Society. The early ideas incorporated by the pair included the natal star with which we are now familiar, but also a woman seated with a child and a stork. These themes can be seen in the sketches for the President’s badge and College seal.

George Bellew, Somerset Herald in Arms of Ordinary, was consulted for his opinion about the designs. While the ideas were in keeping with the formal rules of heraldry, Mr Bellew and many of Blair Bell’s colleagues recommended that a simpler device would be preferable:

‘What a Corporation wants (I venture to suggest) is something which is both relevant and easily recognised, and of these two qualities I am of the considered opinion that the latter, the distinctive quality, is the most important. In designing Arms one has to bear in mind the ideas and tastes not only of the past but also of the future. And simplicity is probably the most likely quality never to be criticised.’

With this letter, again reported in Blair Bell’s history, Mr Bellew enclosed two new designs focusing on the natal star, which he describes as follows: ‘The one is a natal star within an orle of rays, which conveys to my mind birth, life and light in the darkness. The other is a natal star against a sky half night and half day, which suggests to me that the College is associated with phenomena that, of necessity, [are] unaffected by night or day.’

The second of these designs met with broad approval within the College and, following further development work by Blair Bell and Bellew to incorporate the setting sun and crescent moon above the shield, the coat of arms was granted in 1931.4 The crest also included the motto ‘Super Ardua’, which was taken from Blair Bell’s personal coat of arms.5

The new College coat of arms was used in various forms to brand activities, such as on the programme for the first annual dinner.
Blair Bell used it for his 1930 Christmas card, together with an explanation of the symbolism, and it was also developed into a seal and a presidential badge.

1950 rebranding

What became of the supporters, the figures standing either side of the shield in the first designs? When the College of Arms was consulted, it transpired that the British College of Obstetricians and Gynaecologists would not be eligible to use this element of heraldry. However, once the College was granted its Royal Charter in 1947, Council again approached George Bellew for his advice about including this device in the arms.6

Blair Bell’s original thought had been to represent practitioners of obstetrics and gynaecology at the time of the College’s foundation by depicting a Fellow in a College gown on one side and dressed for surgery on the other. This idea received the support of various eminent Fellows, including Fletcher Shaw. However, Mr Bellew again advised caution and discouraged the use of figures in modern dress, giving the National Coal Board’s final choice of ‘black lions of England’ rather than the figure of a miner as an example of good practice.6 Allegorical figures were suggested and designs were presented which depicted Aesculapius, god of healing, on the right and a woman carrying a staff topped with a crux ansata, the symbol of life, on the left. While these figures were perhaps more timeless, they did arouse strong feeling among members of Council. One Fellow, Farquhar Murray, described the figures in an early sketch as ‘seminude’ and ‘pornographic’, though he did reconsider once he had seen a more polished version. The full crest as we know it was finally approved by the College of Arms in March 1950.7

Modern use

The coat of arms was later incorporated, together with a name style and strapline, into a logo for the College – the familiar logo for many years. However, although the coat of arms is impressive in its own right, it has proved difficult to incorporate it into the many uses to which a corporate logo is put in the present day.

Following much discussion and in conjunction with an external marketing company, a modernised logo has been developed which takes us back to first principles and uses a simplified shield with no crest or supporters. The name style and strapline have been updated. The new design was approved by Council in September 2010. This design will gradually replace the existing logo during 2011 and you will see a strengthening of the College identity across all the work we produce.

The coat of arms will not disappear. It is still our official seal and will continue to be used on examination, membership and other certificates and some other official documents.

References
6. Archive reference: RCOG/H2/6, Correspondence with the College of Arms.
College news

Annual General Meeting notice

The Royal College of Obstetricians and Gynaecologists Annual General Meeting (ordinary meeting) will be held in the College on Saturday 21 May 2011 at 9 a.m.

The following business will be transacted:
1. Minutes of 2010. To receive the minutes of the last meeting held on 22 May 2010.
2. Trustees’ report and audited financial statements for the year ended 31 December 2010. Copies will be available at the meeting.
3. Election of auditors for 2011. The appointment of auditors for 2011 will be reported.
4. Election of College Officers. The election of College Officers 2011 will be reported.
5. Election to Council. The election of members of Council for the year 2011–2012 will be reported.

Ian Wylie
Chief Executive
February 2011

Fellows’ admission ceremony – 24 September 2010

The President admitted three Fellows ad eundem and 184 new Fellows during the Fellows’ admission ceremony held on Friday 24 September 2010 at the College. He also presented the Eardley Holland Gold medal, which is awarded every 5 years for original work of outstanding merit in the science of obstetrics and gynaecology; or for outstanding work as a practitioner or teacher of such sciences; or for the authorship of a literary work or works upon such sciences.

Members’ admission ceremony – 26 November 2010

The President admitted five Fellows honoris causa and 176 new Members during the Members’ admission ceremony held on Friday 26 November 2010 at the College.

Katherine Jane Collins received the Prize Medal for being the candidate who achieved the highest mark in the Membership examination. Our congratulations go to her. Laura Jane Pye received the Prize Medal for being the candidate who achieved the highest mark in the Diploma examination. Our congratulations go to her.

Fellows’ admission ceremony

Fellows ad eundem
Professor Anibal Faúndes, Brazil
Professor Louis Keith, USA
Professor Felice Petraglia, Italy

Eardley Holland Award
Professor Charles Henry Rodeck FRCOG, England
Infections during pregnancy are a major cause of death and disability for mothers and their babies in both developed and developing countries.

The articles in this special themed issue of BJOG highlight significant viral, bacterial and microbial infections that complicate pregnancy. The way each one causes damage and how mothers and fetuses respond (or sometimes fail to respond) is described. Prevention and treatment strategies that are currently available and priorities for future research are presented in reviews, commentaries and original research articles.

This themed issue brings an international focus to the problem of infectious disease in pregnancy and we hope will serve to stimulate urgently needed efforts to reduce the resulting morbidity and mortality. The need for improved and affordable interventions in resource-poor areas is especially highlighted.

For readers wanting a state-of-the-art update on infections affecting pregnant women around the globe, this issue is an exceptionally useful resource for all clinicians involved in maternity care and for researchers striving to improve the health of pregnant women and their newborn infants.

Dr SS Witkin, co-editor of the BJOG themed issue, added, ‘Infectious causes of preterm delivery and the resulting perinatal morbidity and mortality remain a major problem in both developed and underdeveloped countries. There is an urgent need to find out more about how individual microbial pathogens cause their adverse effects, define critical areas of research priority and highlight specific examples where improved clinical interventions can be introduced. The BJOG themed issue on infections in pregnancy brings an international focus to these areas and hopefully will stimulate further efforts to improve the health of pregnant women and their newborn infants.’

Dr Julia Hussein, an expert in public health in the developing world, explained, ‘Millions of women and their babies today still die of infections in pregnancy every year. Most of the deaths occur in developing countries from conditions like puerperal sepsis, malaria, HIV/AIDS and tuberculosis, despite our knowledge of effective prevention and treatment strategies. The papers in this themed issue include up-to-date reviews on how some of these infections affect pregnant women and help to throw light on why avoidable mortality and morbidity continue to occur.’

Dr Austin Ugwumadu, an expert in subclinical perinatal infections and fetal inflammation, added, ‘Novel perinatal infections including group B streptococcus, HIV, parvovirus B19 and new hepatitis viruses have emerged in the last three decades alongside abnormal shifts in the vaginal flora such as bacterial and aerobic vaginosis. These newer infections have rightly shifted the focus of research attention away from traditional TORCHES group of intrauterine infections, which dominated this arena for most of the last half century even though they resulted in a relatively small number of fetal/neonatal syndromes. This themed issue of BJOG features reviews, commentaries and original research papers which focus on a wide range of significant and topical perinatal infections affecting pregnant women in developed and developing countries.’

For reasons of space limitation we could not include all the high-quality contributions in the themed issue and readers are well advised to watch out for more papers on prenatal infections in forthcoming regular issues of BJOG. You can access the themed issue for free online here: http://tinyurl.com/2uz3585.

**BJOG podcast: Recurrent miscarriage and heart attack: common pathways?**

BJOG’s latest podcast is now available to download from www.bjog.org or iTunes. This brief video includes a discussion of a recently published paper on the association between recurring miscarriage and family history of ischaemic heart disease.

A panel of experts, chaired by Dr Dimitrios Siassakos (BJOG Journal Club Editor and Trainee Scientific Editor), posed insightful comments and questions to the first author of the paper, Professor Gordon Smith (Head of the Department of Obstetrics and Gynaecology at the University of Cambridge).

Dr David Williams, Consultant Obstetric Physician at the Institute for Women’s Health (London, UK), discussed the statistical relevance of the paper and the robustness of the results with Professor Smith while Professor Siobhan Quenby, Professor of Obstetrics and Honorary Consultant at the University of Warwick/Birmingham Heartlands Hospital, probed into the suggestion that an epigenetic phenomenon may explain the association between ischaemic heart disease and recurrent miscarriage.

Professor Phil Steer, Editor in Chief of BJOG, was also part of the panel and questioned the possible molecular mechanisms that could be involved with the association found in this paper.

The discussion features questions from all these experts and provides an accessible means for the listener to learn more about the significance of the study and to explore the role it could play in spurring future research investigating the underlying mechanisms/genetic predispositions that link recurrent miscarriage and cardiovascular disease.

**Greener options for Membership Matters**

Membership Matters is also available through the RCOG website (http://www.rcog.org.uk/membership-matters). Should you prefer not to receive the printed magazine or would like to use the website as a greener option for viewing the magazine, please inform the Member Records department via email at memberrecords@rcog.org.uk or by telephone on +44 (0)20 772 6303.
Consumers’ Forum update

GILLIAN BAKER CHAIR, CONSUMERS’ FORUM

Election of new Chair

It gives me great pleasure to report that following my 3 years as Chair of the Consumers’ Forum, Cath Broderick has been elected as my successor with effect from 1 May 2011. Cath has a distinguished background of work in patient and public involvement throughout the health service. Many of you may already have met her in College committees. Her particular interest is empowering patients, particularly those from groups who are traditionally hard to reach for reasons of gender, ethnicity, age, disability, faith or religion or sexual orientation. Cath has worked with many organizations and bodies, designing and delivering patient and public engagement methods, projects and expert training programmes to support them in actively engaging communities and supporting people to get involved. I commend her to you and know she will be a powerful voice for the consumer and a great leader of the Forum.

Programme of public lectures

Professor Lesley Regan gave a public lecture on fibroids in March 2011. The lecture will be webcast and placed on the College website. Webcasts of earlier public lectures commissioned by the Consumers’ Forum have attracted a substantial number of hits, which means that we are now reaching a very large audience with our lecture series. The second lecture this year is due to take place on 15 September 2011 on diet and lifestyle. Details of this lecture are still being discussed. The Consumers’ Forum is keen to play a part in the current debate about the growing public health concerns surrounding obesity and its effect on women’s health. Members of the Forum are already involved with the Patient Information Committee in developing patient information on reducing the risk of obesity in pregnancy and after birth. It is hoped that this will appear at the same time as the September event and contribute to raising the profile of this area of growing concern. Members and Fellows of the College are most welcome to attend these events.

The new Membership Matters

RICHARD WARREN HONORARY SECRETARY

I do hope that you enjoy reading the new Membership Matters. The College Officers and the Services Board are very keen to improve communication with our membership, and have reviewed the content and format of RCOG News and RCOG Update, the main portals of communication. The internet and email offer a fast and international means of communication, speedily able to propagate news and canvass opinion. The new RCOG Scanner aims to keep members up to date in this way. Accordingly, the content of hard-copy publications can be changed as the Scanner takes on the role of news delivery. Membership Matters is designed to be of diverse interest to our Fellows and Members and, while these inaugural articles have been written as a result of suggestions, they are only a start: the future of this magazine is in your hands. Please do let us know how you would like it to be shaped; we would be delighted to hear of suggested themes and articles.

Rebranding

The branding of any organisation is extremely important. A clear, modern but professional image should enable immediate recognition and contain a simple message that represents the ethos of the organisation. What does the RCOG do and what is its role? The RCOG is a charitable membership organisation and its image must bridge both its professional and lay roles. After considerable research, discussion and some heated debate, the RCOG has changed its logo and strapline. This issue of Membership Matters contains an excellent article on the development of the RCOG brand, culminating in this present launch. We hope that you will like the widely considered result which is the culmination of so many views!

In memoriam

Fellow ad eundem
Professor Emeritus Axel Ingelman-Sundberg, Sweden

Fellows
Dr Esmat Abdel-Mottalib, England
Dr Alexander Wilson Andison, Canada
Miss Margaret Aureol Austin, England
Dr James Wilson Cordiner, Scotland
Dr Philip Arnold Deck, Australia
Mr Roger Duchene de Vere, England
Dr David Anthony Stirling Eddie, England
Mr Karl William Hancock, England
Dr David Youn Sen Liang, Canada
Dr George Kokumo Oyakhire, Nigeria
Miss Marjorie Mima Paterson, Scotland
Mr Elliot Elias Philipp, England
Mr Hujohn Armstrong Ripman, England
Miss Helen Margaret Russell, England
Miss Nirmala Hirji Shah, England
Mr Thomas Edgar Torbet, Scotland
Professor LGR Van Dongen, South Africa
Mr Geoffrey David Ward, England

Member
Miss Anna Ruth Kemp, Wales

Dr Abiodun Odunlami Keleko, England
Dr Margaret Beth Lawson, South Africa
Dr David Youn Sen Liang, Canada
Dr George Kokumo Oyakhire, Nigeria
Miss Marjorie Mima Paterson, Scotland
Mr Elliot Elias Philipp, England
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Mr Elliot Elias Philipp, England
Mr Hujohn Armstrong Ripman, England
Miss Helen Margaret Russell, England
Miss Nirmala Hirji Shah, England
Mr Thomas Edgar Torbet, Scotland
Professor LGR Van Dongen, South Africa
Mr Geoffrey David Ward, England

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Branching out – franchised RCOG courses move into new regions

The RCOG has always produced a versatile programme of postgraduate training conferences and courses for its membership. Events have always been based at the College premises in the UK, making it difficult for international members and fellows to participate and experience them. To embrace a changing environment and our growing international membership, the RCOG has been investigating ways in which we can deliver regional training courses. Since 2008, the RCOG has opened the doors for many committees, organisations and individuals to organise training courses locally.

One committee to take advantage of this opportunity is the RCOG North Zone in Delhi, India. The RCOG North Zone India has been successfully delivering RCOG training courses and is now expanding into video conferencing, whereby specialist conferences will be broadcast locally.

Mr Sanjeev Sharma FRCOG from Liverpool has been actively involved in developing a series of training courses internationally. In particular, he has been collaborating with Dr Urvashi Jha FRCOG, Chair of RCOG North Zone India, to establish local RCOG courses. His thoughts on how he became involved in RCOG training courses are as follows: ‘For me it started with a conversation I had with the then RCOG Senior Vice President, Dr Anthony Falconer. It was October 2008 and I wanted to discuss with Dr Falconer the ways in which the RCOG could help with training courses in India and particularly in Delhi. For some time, Dr Jha and other members of the College in Delhi had been running training workshops and MRCOG Part 1 and 2 revision courses for local postgraduates. These courses were extremely popular and were organised and run by a dedicated group of Fellows and Members. Nevertheless, Dr Jha and her team were keen to run RCOG-approved courses in Delhi which could be delivered by the local faculty.’

During this time the College was simultaneously exploring the concept of franchising, while establishing a mechanism to monitor and maintain the quality of courses with the RCOG badge. The Basic Practical Skills course was selected as a franchise pilot to be delivered in Delhi. The Basic Practical Skills course was seen as a natural choice for franchising as its curriculum was generic and delivery of the course could be organised with relative ease. It was important that the course package included a set-up guide as well as the teaching and course materials. Since the participants received their certificates directly from the College, it was important that the organisers followed the curriculum structure and assessment tools provided to ensure the original course’s standards were maintained.

So, how long did the initial planning process take and what was involved? The RCOG provided the necessary information in the form of guidance notes for the course. The planning and organisation commenced in Delhi in January 2009, with recruitment and training of local faculty members. Liaison with local Members and Fellows was the starting point, as these people understand the local system and are familiar with the RCOG’s culture of training and its aims and objectives in raising awareness of women’s health issues. Commitment, enthusiasm and hard work were obvious in all the faculty members.

The next step was to select a venue and ensure all the equipment was available. The Ethicon Endo-Surgery Institute was the chosen venue as it was able to provide the same facilities that are available in the College’s own Skills Centre in London; however, it did not have any equipment for the obstetrics skills. Between January and March 2009, the local organisers ordered and took delivery of three obstetric manikins and everything else that was needed for the obstetric component of the Basic Practical Skills course.

The final step was marketing and promotion of the course, which was done on the RCOG website and in relevant RCOG publications. The RCOG North Zone recognised that the initial courses were not yet established within the local market and advertised the course in the local medical media.

The RCOG North Zone India held the first Basic Practical Skills course in March 2009, immediately after the Annual All India Congress Committee—RCOG Conference, which was held in Delhi. The benefit of a pre-congress workshop meant instant exposure to a large audience and a chance to gauge interest from local delegates. The course was deemed successful based on the feedback received from the 65 participants and 26 trainers.

The Basic Practical Skills course is now well established in the RCOG North Zone’s training calendar. It is held twice a year, in January and July. The course accepts a maximum of 25 participants and is run over 2 days rather than 3 as the faculty members cannot take 3 days off from their busy practices. Mr Sharma expressed that ‘most participants have not been to anything like the Basic Practical Skills course with its emphasis on hands-on experience and one-to-one instruction, therefore it is important that their attention is not diluted by too many participants or too few faculty members.’

Since 2009, the RCOG North Zone India has also franchised the MRCOG Part 2 revision course (written and objective structured clinical examination) and has begun using video conferencing to broadcast College conferences to Delhi, such as the Maternal Medicine conference, which attracted over 100 local delegates.

The RCOG North Zone India has been very proactive in the development of educational resources. RCOG President Dr Falconer reported that ‘this project developed by Mr Sharma and Dr Jha is a brilliant example of joint working and should form a model of excellence for other international representative groups’.

For Fellows and Members wishing to set up their own franchised course, we advise you to start a discussion with the RCOG Conference Office in London by emailing Rakhi Shah, Research, Development and Marketing Manager (rshah@rcog.org.uk).
The Underrated Umbilical Cord
1 June 2011
This meeting will be of interest to all involved in the labour ward and will update on recent Cochrane reviews and changes in RCOG and International Liaison Committee On Resuscitation (ILCOR) recommendations. The umbilical cord acts as the lifeline to the fetus during pregnancy but its role at birth is underrated as placental function does not cease instantly after delivery (unless clamped). Strategies for identifying babies at risk of cord complications during labour will be presented. The strategy for managing cord complications requires an understanding of the physiology of transition at birth and a new level of multidisciplinary cooperation by all those involved in the care of the mother and baby at birth.

Advanced Course in Gynaecological Ultrasound I: Early Pregnancy, Reproductive Medicine and Benign Gynecology
Joint RCOG/ISUOG Meeting
3–4 June 2011
The first of a planned two-part specialist programme in gynaecological ultrasound, organised by ISUOG and the RCOG. This first course focuses on:
- Early pregnancy – understanding the mechanisms of miscarriage; longitudinal assessment of early pregnancy growth; diagnosis and management of non-tubal ectopic pregnancy.
- Fertility and reproductive medicine – characterising uterine congenital abnormalities; revisiting the diagnosis of PCO; cycle monitoring and OHSS and a review of treatment of endometriosis and fibroids.

A full, detailed programme and online registration can be found via the RCOG and ISUOG websites.

Basic Colposcopy
15–16 June 2011
Cervical cancer remains the second most common malignancy in women worldwide. The national cervical screening programmes in Britain have been hugely successful in reducing the incidence of and deaths from the disease. Part of this success lies in using colposcopy as a secondary screening tool. We have now begun implementation of a vaccination programme aimed at preventing the development of around 70% of high-grade CIN and subsequent cervical cancer. The course will cover discussion on the latest controversies and advances in screening and colposcopy. It will also cover the NHS CSP guidelines, HPV testing, HPV vaccines, quality assurance issues and the clinical management of difficult situations in colposcopy with interactive case examples.

Gynaecological Cancers – Biology and Therapeutics
Follow-up Meeting to the 60th RCOG Study Group
23 June 2011
Gynaecological cancers are categorised as ‘rare’ diseases, though collectively they affect over 16000 women in the UK each year. Many aspects of these conditions remain unresolved, and there is a need to expand our understanding of both disease biology and optimum therapies.

This meeting follows the 60th Study Group involving experts from the UK and abroad. The aim of the meeting is to present the ‘cutting edge’ of basic, translational research and clinical trials. The book *Gynaecological Cancers – Biology and Therapeutics* from the Study Group will be included in the delegate pack.

Intrapartum Fetal Surveillance
13 September 2011
This course aims to provide a clinical update on intrapartum fetal surveillance for doctors and midwives who work on the labour ward. The National Health Service Litigation Authority (NHSLA) compensation figures for brain-damaged children and the Chief Medical Officer’s chapter in his annual report ‘500 missed opportunities’ emphasises that there is still need for improvement. The NHSLA has made formal attendance at cardiotography (CTG) courses a mandatory requirement to receive Clinical Negligence Scheme for Trusts (CNST) discounts.

This course will provide knowledge at the basic and advanced level to improve safety and quality of care and will help to keep the lawyers away.

Psychiatric Diseases in Pregnancy
22 September 2011
This meeting is aimed at all health professionals who care for pregnant women. This includes senior and junior obstetricians, psychiatrists, midwives, general practitioners, psychiatric nurses, counsellors and social workers.

The lectures will be a mix of theory and practical advice, with topics ranging from psychiatric drugs in pregnancy to debriefing after childbirth. Lectures will be delivered by clinicians from a range of disciplines, reflecting the multidisciplinary approach needed to care for these women.

NICE Guidelines in Women’s Health – Have They Made a Difference?
26 October 2011
For the last decade NICE guidelines have had a major impact on the delivery of health care in the NHS, but given the enormous resources involved in producing them it is fair to ask the question: ‘Have they improved patient care?’

The RCOG is holding a meeting to consider four NICE guidelines produced in the last 5 years dealing with different aspects of women’s health. Two are obstetric (Diabetes in Pregnancy and Induction of Labour) and two are gynaecological (Heavy Menstrual Bleeding and Long Acting Reversible Contraception).

The format is that for each topic a summary of the relevant guideline will be presented, followed by a critical review of whether the guideline has improved the outcome of women in those areas.
Forthcoming dates, conferences and courses at the RCOG  

**Basic Practical Skills in Obstetrics and Gynaecology 2011**

‘Very helpful course, can’t recommend it highly enough.’
BPS Course Delegate, May 2009

Tuesday 27 – Thursday 29 September
Monday 10 – Wednesday 12 October
Tuesday 29 November – Thursday 1 December

**Advanced Training Skills Modules**

**Early Pregnancy and Gynaecological Ultrasound**
7–8 September 2011

**Training the Trainers**
3–4 October 2011

**Advanced Labour Ward Practice**
*Joint RCOG/BMFMS Meeting*
2–4 November 2011

**Intermediate/Advanced Hysteroscopy**
*Joint RCOG/BSGE Meeting*
28–29 November 2011

**Laparoscopic Surgery**
*Joint RCOG/BSGE Meeting*
30 November 2011

**MRCOG Revision Courses**

The RCOG revision courses provide the inside track on how to study for the MRCOG Part 1 and 2 exams.

‘This is one of the most beneficial courses I have ever attended.’
MRCOG Part 1 Course Delegate, July 2009

‘The entire course was very educational and helpful, it helped me focus and get motivated to keep going with my studying for the exam.’
MRCOG Part 2 Course Delegate, January 2009

**MRCOG Part 1 Revision Course 2011**
Monday 4 – Friday 8 July

**MRCOG Part 2 Revision Course 2011**
Wednesday 25 – Friday 27 July

**MRCOG Part 2 OSCE Revision Course 2011**
Monday 31 October – Friday 4 November

Fellows and Members save over 15 % on the standard delegate rate. RCOG conferences and courses now offer new rates for Fellows/Members, Trainees and allied healthcare professionals.

To find out more about the new prices and the terms and conditions and what courses are available to you and your colleagues, please visit www.rcog.org.uk/events or call the Conference Office on +44 (0) 20 7772 6245. Why not add us on Facebook to keep up to date with all the latest events and courses? Just search for RCOG Events.

**Calendar 2011**

**MAY**

3–6 MRCOG Part 2 OSCE Revision Course
9–11 MRCOG Part 2 (OSCE) Examination
12–13 Risk Management in Medico-Legal Issues
13 Teacher in O&G
16–18 Basic Practical Skills in Obstetrics and Gynaecology
20 Members’ Admission Ceremony
23–24 Forensic Gynaecology
25 How to be a College Tutor
29–27 Surgical Innovations: Research, Guidelines and Training

**JUNE**

1 The Underrated Umbilical Cord
3–4 Advanced Course in Gynaecological Ultrasound
* (Joint RCOG/ISUOG Meeting)
9–10 SpROgs 2011 – Liverpool
13 Gynaecological Cancers – Biology and Therapeutics. RCOG Study Group Follow-up Meeting
15–16 Basic Colposcopy Course
24 PROMPT: Training the Trainer
30 Examiners’ Training Course

**JULY**

4–8 MRCOG Part 1 Revision Course
22 Councillors’ Dinner/Ms Beryl Stevens MBE Farewell Dinner
25–27 MRCOG Part 2 Revision Course

**SEPTEMBER**

5 MRCOG Part 1 Examination
6 MRCOG Part 2 (written) Examination
7–8 Early Pregnancy and Gynaecological Ultrasound
13 Intrapartum Fetal Surveillance
15 Consumers’ Forum Public Lecture
22 Psychiatric Diseases in Pregnancy
23 Fellows’ Admission Ceremony
23 Fellows’ Dinner
27–29 Basic Practical Skills in Obstetrics and Gynaecology
27–30 9th RCOG International Scientific Meeting – Athens

**OCTOBER**

3–4 Training the Trainers
8 DRCOG Examination
10–12 Basic Practical Skills in Obstetrics and Gynaecology
13 Female Sexual Dysfunction
13 How to be a College Tutor
14 College Tutors’ Meeting
17–18 Understanding Urodynamics
26 NICE Guidelines in Women’s Health – have they made a difference
31 Oct MRCOG Part 2 OSCE Revision Course
 – 4 Nov

**NOVEMBER**

2–4 Advanced Labour Ward Practice
8–9 BSUG Annual Scientific Meeting
14–16 MRCOG Part 2 (OSCE) Examination
17–18 2nd European Conference on Simulation in Women’s Health
19 RCOG Careers Fair
22–24 RCOG Annual Professional Development Conference
25 Members’ Admission Ceremony
25 Annual Dinner
28 Early Pregnancy Cerclage
28–29 Intermediate/Advanced Hysteroscopy
29 Nov Basic Practical Skills in Obstetrics and Gynaecology
 – 1 Dec
30 Laparoscopic Surgery

**DECEMBER**

6–7 RCOG Annual Academic Meeting and William Blair Memorial Lecture
7 Christmas Lecture for Young People
Have you accessed the RCOG webcasts yet?
The RCOG webcasts are a series of online lectures and courses available for those unable to attend RCOG Conferences and Courses. Enjoy the benefits of webcasting:

- Obtain continuing professional development credits for accessing the pay-per-view webcasts.
- A flexible approach to learning.
- Save money to use for other educational activities.
- Avoid travel time, staying in hotels and being away from home.
- Keep in touch with the latest advances in your field, especially if you are from outside the UK and find it difficult to travel to the RCOG to attend conferences.

Recent additions to the webcast library include:

32nd British International Congress of Obstetrics and Gynaecology, June 2010
Misogyny and women’s health – Dr David Grimes
Cosmetic Genital Surgery – Professor Linda Cardozo

2010 Eponymous Lectures
J Y Simpson Oration Lecture: Mosi Oa Tunya ‘The Smoke that Thunders’ – Dr Tony Falconer at SpROGs, June 2010

William Fletcher Meredith Shaw Lecture: Are low risk fetuses more likely to die than those at high risk? – Professor David James at Management of the Labour Ward course, June 2010

Green-Armytage Anglo-American Lecture: The next 30 years of ART – Professor William Ledger at Subfertility and Reproductive Endocrinology course, April 2010

RCOG Consumers’ Forum Public Lectures
Motherhood and the Mind
Sex and the Menopause

Why not log on today and take a look?
www.rcog.org.uk/webcasting

James Young Simpson Bicentenary Celebrations, 2–4 June 2011

RCPE in association with RCOG
One-day Symposium: Maternal Medicine – 2 June 2011
Clinicians are increasingly faced with pregnant women with complex medical conditions such as cardiac disease, obesity, diabetes and other chronic conditions. This Symposium provides an update for all clinicians involved in the management of medical conditions in pregnancy.
http://events.rcpe.ac.uk/events/115/maternal-medicine
Contact: Eileen Strawn (e.strawn@rcpe.ac.uk)
Visit www.stratog.net and receive one free tutorial

For further information, contact us on 020 7772 6431 or email us at stratog.net@rcog.org.uk
Standards update

DR DAVID RICHMOND VICE PRESIDENT (STANDARDS)

Being appointed to the post of Vice President (Standards), while a privilege, has brought home to me the magnitude of trying to achieve the College’s aim ‘to set standards to improve women’s health and the clinical practice of obstetrics and gynaecology in the British Isles and across the world’. It is a role I welcome and will do my utmost to deliver over the next 3 years.

In the UK, the last few years have seen NHS policy shifting from targets to high-quality, safe and effective services with a positive patient experience. This change has been described as Darzi’s legacy and has been reinforced by the coalition government’s white paper, Equity and excellence: Liberating the NHS.

The government’s vision is for a healthcare system which is run from the bottom up, with ownership and decision making shifting to patients and local professionals, helped by easy access to the information they need about the best GPs and hospitals. The future success of healthcare services will be measured through clinical outcomes rather than process targets, as has been the case until now. This change poses a big challenge, particularly within the framework of massive financial constraints which we all see daily. The proposals were set out in the white paper and several associated consultations:

- Transparency in outcomes – a framework for the NHS
- Commissioning for patients
- Local democratic legitimacy in health
- Regulating healthcare providers
- An information revolution
- Greater choice and control.

I have led the College’s responses with the Standards team, taking on board the views of Fellows and Members (collated via the President’s questionnaire – UK) and those of Council, your elected representatives. The rapid pace continues – we had two further consultations to respond to during March: the public health document Healthy lives, healthy people: Our strategy for public health in England and Healthy lives, healthy people: Transparency in outcomes. Proposals for a public health outcomes framework.

These reforms in the UK will mean enormous changes to the provision of services and the way we work. I see this as an opportunity for the College to demonstrate its leadership role and to champion the standards and guidelines within our specialty. The RCOG guidelines and standards documents are highly regarded and should form the template for any future commissioning proposals. In addition, the College has set up an Expert Advisory Group with a lay chair (Dame Joan Higgins) to design high-quality women’s health care, addressing the question of what the service should look like. We hope to complete this important work by August 2011 to inform ministers and commissioners so that the design of future services will be led by the College.

Finally, I am delighted to inform you that we have achieved the Information Standard certification for RCOG patient information. Our Green-top Guidelines achieved NHS Evidence accreditation in February 2010. These are the highest awards in the UK for guidelines and patient information, so we can be very proud of our achievements. These would not have been possible without much hard work by our committee members and the College staff. My sincere thank you to the Guidelines Committee and the Patient Information Committee, in particular Mrs Caroline Overton, Dr Philip Owen and Dr Alison Kirkpatrick for their leadership.

The hard work continues and the following 10 documents have been published since January 2011:

- Green-top Guidelines on Maternal Collapse in Pregnancy and the Puerperium, Operative Vaginal Delivery, Placenta Praevia and Placenta Praevia Accreta: Diagnosis and Management, Reduced Fetal Movement, Tocolytic Drugs for Women in Preterm Labour and The Management of Vulval Skin Disorders;
- Patient Information on Air Travel and Pregnancy;
- Scientific Advisory Committee Opinion Papers on Diagnosis and Treatment of Gestational Diabetes, Multiple Pregnancy Following Assisted Reproduction and Reproductive Ageing.

All the documents are available from the RCOG website at http://www.rcog.org.uk/womens-health.

All the above and the work of the Standards Directorate, including guidelines, standards, the heavy menstrual bleeding audit, research, revalidation and patient information, will ensure that my time at Regent’s Park is never dull. Please do visit the website for the latest guidelines and patient information.

The design of future services will be led by the College.

Q&A/letters

We would like to encourage the membership to submit letters to the College which will be answered and published in Membership Matters. These letters can take the form of a question or feelings on a particular professional topic. Please send any letters to Luke Stevens-Burt, Head of Corporate Affairs (lstevens-burt@rcog.org.uk).
Education update

PROFESSOR WENDY REID VICE PRESIDENT (EDUCATION)

The RCOG has an international reputation for delivering high-quality education and training. However, there is a need both to take a look at the content of our educational packages and to develop a more coordinated approach, particularly to working with international colleagues. We face perhaps more NHS ‘politics’ than at other times and this is as true for the education sector as for the health service as a whole.

The politics

The challenges of a new health bill that charges primary care with the task of commissioning services is matched by the white paper Liberating the NHS: Developing the healthcare workforce, which is out to consultation at the time of writing this article. The themes within the white paper do emphasise the importance of education and training for the future health of the NHS, but there are significant differences in the delivery of training, the accountability, the structures to support education and training and, inevitably, the funding proposed. The College is clear that there are opportunities for us to expand our role in setting the standards of education and training and in providing the measure of quality for our trainees, trainers and programmes. We need to ensure that obstetrics and gynaecology is represented at all levels of the system. Any Fellow or Member who has an opportunity locally, regionally or nationally is welcome to work with us in this ‘new world’.

Planning the future workforce

Workforce planning is a central component of the white paper and the College is working with the new Centre for Workforce Intelligence in this area. We will see an increase in the number of doctors obtaining their Certificate of Completion of Training (CCT) over the next 3 to 4 years. The completion of the first electronic RCOG census is a significant achievement. The information provided gives our profession a solid base from which to expand consultant-delivered care and we are working together across Education, Standards and the wider College to impress upon employers the effectiveness of this model of care. Recognising the difficult financial climate, the Academy of Medical Royal Colleges has a working party looking at the evidence for a consultant-delivered service that will provide information about quality, efficiency and outcomes to balance the ‘cost’ arguments and help both commissioners and employers realise the benefits to patients. This work will be supported by the RCOG working party on the future role of the consultant and will link with the RCOG expert group on high-quality women’s health care.

Education

There are many excellent educational packages developed within or for the RCOG. One of the challenges has been communicating the diversity and availability of these resources. This is particularly important as UK-based Fellows and Members face increasing difficulty in taking leave from trusts to attend courses, deliver lectures, provide input to examinations and so on. The College has therefore set up a process of capturing all the bright ideas and innovative thinking, helping with the development of ideas to fruition and then ensuring the place for each educational ‘product’ is defined and communicated widely. The educational product management and executive groups provide a very exciting new way of working. More information and guidance about how to submit ideas is on the RCOG website (http://www.rcog.org.uk/productproposals). The aim is for every activity that has educational value to be documented and captured by this group. The potential benefit to the College and its Fellows and Members is the ease with which we will be able to identify gaps we should fill, assist colleagues visiting international centres with educational material and develop the RCOG franchise fully.

Training

Over the past few years, the work put into developing the curriculum and Advanced Training Skills Modules has provided very secure training up to CCT level. The proposed revalidation of doctors provides us with the impetus to develop College support for continuing professional development beyond our present levels. Much of the education and training provided for specialist trainees has relevance to more senior doctors. The future of consultant practice means that flexibility and the opportunity to re-skill or develop new skills will become important.

The RCOG curriculum is 3 years old. Aspects of the content are being reviewed, with an emphasis on links between the modules and having clear outcomes for each module and each stage of training. The use of a training matrix has been pioneered and will enable trainees and trainers to see what skills and professional attributes are necessary at the end of each year of training by using a simple chart. The Trainees’ Committee is a vital group in the College and trainees now have input into all aspects of education and training. The excellent work created by the trainees’ survey continues to drive important areas of activity for the College, the most recent being a proposal to reduce the incidence of bullying and inappropriate behaviour.

I look forward to my next few years serving as Vice President (Education). There are many challenges and changes that lie ahead, but I intend to meet these with positivity and ensure that they are integrated into the system in the best possible manner.
Each issue of *Membership Matters* will feature an interview with a different Honorary Officer so that you can get a better idea about them, their roles and what makes them tick. If there is something in particular you would like to ask them, please submit your question to Marion Goonewardene (mgoonewardene@rcog.org.uk). The next issue will feature the President, Dr Tony Falconer.

**Interview with Mr Ric Warren FRCOG, Honorary Secretary**

**What does the Honorary Secretary actually do?**

The Honorary Secretary is responsible for the smooth running of the College and also acts as a minister without portfolio, in particular supporting the President. Also, the administration and infrastructure of the College’s activities are overseen by the Services Board, which the Honorary Secretary chairs. It’s a great position to hold and I thoroughly enjoy it.

**Where did you train in medicine?**

I was a medical student at King’s College Hospital, London and was lucky enough to work there as a senior house officer, registrar, research fellow and senior registrar. I conducted research in ultrasound, with a Medical Research Council grant, developing the innovative technique of chorionic villus sampling. I was very lucky: you couldn’t come out of King’s without broad and excellent training from many of the best experts in the world. I look back on that time with fond memories and acknowledge how important my mentors and training were to my future career.

**What mark would you like to leave at the end of your career?**

I am a clinician at heart and, while I hope I have fulfilled my job as Honorary Secretary to a high standard, I would like my legacy to be with my patients, who I hope remember me as an empathetic and caring doctor. There is, much to a career in medicine in terms of knowledge and application, but sympathy and care of the woman and her family at a time of illness and stress is paramount.

**What advice would you give to those who are just getting started in the specialty?**

I would suggest following those areas of specialist interest or sub-specialisation that you find the most enjoyable and for
which you have aptitude. Pragmatic advice would also be to look to the future and the best job opportunities, steering your training based on your knowledge of employment prospects. Also, realise that those trainees with the best CVs and training are most likely to succeed in the clinical areas, the size of hospital and even the geographical area in which they wish to work. Getting a post as a consultant will be very competitive. My advice is to take every opportunity for education and training and go the extra mile to stand you in good stead.

What did you enjoy most about your training?

Like many, I suspect it was involvement in maternity care that first attracted me to Obstetrics and Gynaecology. This of course was a time when as a medical student you spent 3 months in Obstetrics and Gynaecology, with much of that time spent delivering babies. I thoroughly enjoyed my month in Plymouth on a maternity attachment and, once I had completed my house officer posts, still not sure of the path of my future career, I knew that Obstetrics and Gynaecology was one of the specialties that I wished to explore.

Do you think consultants should be around day and night?

Yes, I believe that it is inevitable, but this should not detract from a fulfilling and enjoyable career. Workforce predictions clearly indicate a need for a reduction in the number of trainees while the need for quality and safety is driving an increase in the number of consultants. If consultants are to work around the clock more regularly, it is essential that lifestyle is considered. Demands on the individual are different at different times of life and the ability to cope with shift patterns and night disturbance deteriorates as you get older. The RCOG’s working party looking at the post-Certificate of Completion of Training role of the consultant must consider these challenges and look at how the evolution of a career over 30 years as a consultant can give the best to patients while being stimulating and enjoyable for the individual.

Outside of clinical care, what have been the landmarks in your career?

Getting involved with the RCOG was undoubtedly very special, although a spell as a clinical director in my trust hospital was also, I now realise, a major influence. I was the first RCOG trainees’ representative on any committee, I joined the RCOG Workforce Advisory Group while I was still a registrar and then, through the role of district tutor, regional adviser and College Council, became closely involved with the RCOG. Continuing my clinical role while working as an RCOG Officer has been extremely busy and time consuming, but the rewards have been wonderful.

Has it been difficult continuing as a clinician while working as Honorary Secretary?

Yes, it has been very challenging. Like most people who take on additional responsibilities, I tried to continue with as much of my clinical work as possible, resulting in a timetable that was approaching being unachievable. I still do most of my College administration at weekends. Naturally, being away from Norwich also throws greater pressure on my colleagues. I am very grateful to them, and my trust, for their forbearance and support.

If you weren’t in this specialty, what do you think you would be doing right now?

There is no doubt that if I had my time again I would wish to follow the same, or a similar, pathway in medicine. I realise, however, that I might not achieve the academic success that is now necessary to enter medical school! What would I then do? I really don’t know! I love design work, but there is one problem: I cannot draw!

What do you see as the important issues facing this specialty in the next 5–10 years?

I have already mentioned the changes all colleges face in a consultant-based service and the impact this will have on the role of the future specialist. However, I suspect that increasing financial constraints and new ways of commissioning will drive the greatest changes. Trying to influence politicians has never been easy, but we must continue to press for higher standards of care despite these increasing constraints.

In our own specialty, I am a firm believer that there is great strength in Obstetrics and Gynaecology remaining together in terms of both training and service delivery. Increasingly diverse laparoscopic skills will undoubtedly develop, but the medicalisation of gynaecology has reduced the number of hysterectomies and it has been realised that not all future consultants will need to be trained in major surgery. However, I am not sure that I have seen acceptance among trainees or employers of the need to follow such a medical pathway.

In terms of the RCOG, greater involvement by the membership and the professional societies at the heart of College activities is essential. Again, a working party is looking into how to improve representation.

As pressure is put on study leave and budgets, travelling to London will become increasingly difficult. The use of modern technology to enhance training, continuing professional development (CPD) and communication must be at the centre of the RCOG’s development. The College has already shown that it can lead in this area, but further developments, including electronic CPD and delivering lectures to regional or local centres, are now necessary.

When you are not working, what do you enjoy doing?

Having just finished editing the RCOG’s report of a working party looking at work–life balance, I realise that a combination of self-inflicted additional roles has gradually taken over my life! I am guilty of not defining time for relaxation. I live in a wonderful part of the country and enjoy all sport. A pub lunch and a long walk with my family and puppy on a deserted Norfolk beach is my ideal Sunday, but something that embarrassingly I do all too infrequently.

And what about your future?

Well, I still have 6 months left as Honorary Secretary and there are a number of areas of unfinished business that will keep me busy. After that, who knows? Every few years I have needed a fresh challenge and I’m sure that the freed-up time will soon be taken up. Certainly, there are a number of clinical areas to which I wish to devote more time and I’m sure that there will be other opportunities. Maybe as well as new areas of work I will be able to go on those long walks!
The regulation of immune cells in normal and abnormal pregnancy

The role of IL-33 and ST2 in normal and pathological pregnancy

Sargent, University of Oxford; John Radcliffe Hospital

During pregnancy the woman’s immune system changes to accommodate the development of the genetically foreign fetus. This project concerns newly discovered results by the applicants that molecules called ST2 (made by the mother’s immune system) and IL-33 (made by the placenta of the conceptus) may be major regulators of this important immune interaction. Moreover, the research will investigate the extent to which failure of pregnancy coincides with abnormal expression of these molecules. In addition, this project will further investigate the role of IL-33 and ST2 in early pregnancy and pre-eclampsia and could make very important new discoveries in why some pregnancies are ‘rejected’ by the mother.

Cardiac Arrest in Pregnancy Study (CAPS)

Cardiac Arrest in Pregnancy Study (CAPS)

Beckett, Bradford Royal Infirmary; Leicester Royal Infirmary; University of Oxford

Estimates of cardiac arrest in pregnancy are around 1/30,000 pregnancies, but there has been no recent assessment of this rate despite the increasing age and morbidity of the antenatal population in the UK. The Confidential Enquiry into Maternal and Child Health report for the 2003–2005 triennium noted 49 cases of perimortem caesarean section where the outcome for the mother was fatal.

The research team proposes using the well established UK Obstetric Surveillance System (UKOSS) method to survey cardiac arrest in pregnancy and perimortem caesarean section in the UK over a period of 3 years. The team anticipates that this will be the first prospective study of these rare events in the international literature. There is an urgent need to assess current practice in the UK. Perimortem caesarean section should improve outcome for the mother if carried out in a timely manner. This project will provide useful data to inform clinical practice in the future. It could significantly improve outcomes for cardiac arrest in pregnant women worldwide.

Boosting immune defences in women with recurrent cystitis without using hormones

Beyond estrogen treatment: unlocking the ability of beta defensin 2 to prevent urinary tract infection in post-menopausal women

Pickard, Newcastle University; The Royal Victoria Infirmary

This research group has great expertise in the field of recurrent urinary tract infection (rUTI) and wants to use it to find out how estrogen treatment enhances natural immunity. Cell lines will be studied to explore the mechanisms whereby adenosine monophosphate (AMP) expression is enhanced. The researchers hypothesise that estrogen treatment reduces rUTI by enhancing AMP expression. To investigate this, they will use in vitro cell-culture models and microarrays to characterise signalling pathways by which estrogen modulates vaginal AMP expression. They will also examine how estrogen therapy alters these pathways using vaginal biopsies/washings obtained clinically from a cohort of 70 postmenopausal women. The results of these analyses will highlight targets for manipulation by novel lines of preventive or adjunctive treatment.

This study has the potential to provide alternative approaches to antibiotics and estrogen treatment. The mix of laboratory and clinical work has a real potential for progress in this condition.

The role of Larp1 protein in the development of ovarian cancer chemotherapy resistance

Larp1, EMT and chemotherapy resistance in ovarian cancer

Blagden, Gary Weston Cancer Centre, Imperial College; Hammersmith Hospitals Trust

This study will be the first to answer fundamental questions about the role of Larp1 and epithelial–mesenchymal transition (EMT) in the development of platinum resistance in ovarian cancer, an event which is responsible for the majority of the 4300 deaths from the disease every year in the UK. The researchers hypothesise that, through its activation of EMT, Larp1 causes chemotherapy resistance in ovarian cancer. This project seeks to understand mechanisms which lead to a more malignant behaviour in ovarian cancer. It has the potential to define a new target for treatment. Importantly, it may also find a marker which could be used to tailor treatment and allow women who are unlikely to respond to platinum-based chemotherapy to be given alternative treatment and avoid the toxicity of ineffectual treatment. It is a novel area for research and this is a well-planned, logical project to be performed by a group with an excellent track record.
The National Reproductive Health Research Network (NRHRN)

The NRHRN was established by the RCOG in February 2008 by a small group of academics aiming to replicate the successful models developed by the Medicines for Children Research Network for obstetrics and gynaecology. That small group of academics, including the RCOG President, became the NRHRN Executive and promptly set about forming a Board which would encourage, support and promote the establishment of clinical studies groups (CSGs).

The NRHRN Board

Representatives from a variety of stakeholders were invited to join the NRHRN Board and a plan of action was drawn up. Eleven CSGs were planned to cover the main areas of the specialty. The relevant specialist societies and charities were consulted and many eagerly agreed to sponsor one or more CSG. In collaboration with the specialist societies, the Board set up a process for the recruitment of CSG chairs and members, based on transparency and competitiveness.

The CCRN Reproductive Health & Childbirth Specialty Group

While the NRHRN Executive was appointing Board members and identifying the areas in which CSGs were needed, the National Institute for Health Research Clinical Research Network established a National Specialty Group for Reproductive Health and Childbirth, which encompasses representatives from the 25 comprehensive local research networks. Professor Thornton, a member of the NRHRN Executive and Board, was appointed as Chair, thus providing cross-representation with the NRHRN and raising its profile. The Specialty Group’s main functions are to improve patient recruitment and advise on local provision of infrastructure to support studies. Professor Andrew Shennan has since become Chair of the Specialty Group and a member of the NRHRN Board.

The clinical studies groups

The CSG is a body which facilitates a multidisciplinary research network for trials in the UK. It provides leadership in trials and as such it should combine expertise with enthusiasm. In addition, the CSG has a role in providing advice to researchers on trials methodology and support for the organisation of approved trials (this can also include support for triallists and trials from beyond the CSG). Ten CSGs have been established within the NRHRN, namely:

- Early Pregnancy, chaired by Mr Davor Jurkovic FRCOG, and sponsored by the Association of Early Pregnancy Units
- Fetal Medicine, chaired by Professor Zarko Alfirevic FRCOG and sponsored by the British Maternal and Fetal Medicine Society
- Intrapartum Care, chaired by Dr Sara Kenyon and sponsored by the British Maternal and Fetal Medicine Society
- Maternal Medicine, chaired by Professor Lucilla Poston FRCOG and sponsored by the British Maternal and Fetal Medicine Society and the MacDonald UK Obstetric Medicine Society
- Pelvic Floor, chaired by Mr Marcus Drake and sponsored by the British Association of Urological Surgeons and the British Society of Urogynaecology
- Post-Reproductive Medicine, chaired by Mr Nicholas Panay MRCOG and sponsored by the British Menopause Society
- Preterm Birth, chaired by Professor Jane Norman FRCOG and sponsored by the British Association of Perinatal Medicine and Action Medical Research
- Reproductive Medicine, chaired by Professor Siladitya Bhattacharyya FRCOG and supported by the British Fertility Society
- Sexual and Reproductive Health, chaired by Professor Anna Glasier FRCOG and sponsored by the Faculty for Sexual and Reproductive Health
- Stillbirth, chaired by Professor Gordon Smith FRCOG and sponsored by the Stillbirth & neonatal death charity.

The post of Chair of the CSG for Menstrual Disorders (to include gynaecological endoscopy and endometriosis) is now being advertised with the support of the British Society for Gynaecological Endoscopy.

An example of how the CSGs are beginning to work is given by Professor Jane Norman, Chair of the Preterm Birth CSG: ‘The CSG has uniquely allowed us to bring together a variety of perspectives to discuss priority areas of research around preterm birth prevention, and then to set up a multidisciplinary group to develop protocols and funding applications. It has enabled us to work on a national basis and fostered collaboration between different groups. It was crucially important in synthesising the funding application and pan-UK support for OPPTIMUM (which is funded by the Medical Research Council and which has now randomised more than 200 participants from 60 collaborating sites across the UK). More recently, the CSG has been working on the role of preinvasive cervical cancer treatment in (inadvertently) increasing the risk of preterm birth and we have developed a multidisciplinary working group of colposcopists, gynaecological oncologists, obstetricians, neonatologists, basic scientists and midwives to address this important problem. The development of both of these agendas would have been much slower without the framework and the funding support of the CSG, and we hope that the CSG will enable solutions to the problem of preterm birth to be more rapidly devised.’

Professor Allan Templeton, Chair of the NRHRN Executive, said: ‘Now that the CSGs are all established we need to look to the future functions of the NRHRN Board, in the light of the College’s strategy for academic medicine and the development of the new Academic Committee.’

For more information about the NRHRN and the CSGs, please visit http://www.rcog.org.uk/national-reproductive-health-research-network.