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Royal College of  
Obstetricians and Gynaecologists

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Bringing to life the best in women's health care

# Tomorrow's Specialist:

The future of obstetrics,  
gynaecology and  
women's health care

Written by  
Nicholas Timmins

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September 2012

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## **Tomorrow's Specialist:**

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and women's health care

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Both medicine and health care are changing, and changing fast.

Better, cheaper and quicker diagnostic aids, ranging from various forms of scanner to blood tests are becoming available. So are digital patient records that can be viewed from anywhere. Electronic decision support systems can help clinicians – doctors, nurses and midwives – to make surer decisions about treatment and care.

Some treatments that previously required surgery can now be undertaken medically. Surgery itself is becoming less invasive. Growing numbers of procedures can now be undertaken using 'key hole' techniques, with lasers replacing scalpels and tiny cameras on the end of optical fibres providing access for treatment without the need for open wound incisions – reducing the trauma, the risks and the recovery period from surgery.

Chemotherapy for cancer, which once required long stays in hospital, can now be provided in patients' own homes. The same applies to intravenous antibiotics for deep seated infections.

Conditions such as diabetes and obstructive lung disease can be monitored by patients themselves, at home, using simple equipment. Access to the internet and email can allow patients to take more control of, and responsibility for, their own care. Both are helping make patients better informed about their own conditions and better able to share decision making about care with those who care for them. For many areas of medicine, there is a genuine choice available about how and where patients can and should be treated.

Far more care can now be delivered outside hospitals: either in people's own homes or in the community, whether at a general practitioner's (GP) surgery, in community hospitals and facilities, or in specialist diagnostic and surgical centres.

Horn and Hardart Self Service

At the same time, however, it has become ever clearer that the more specialised care is best delivered in specialist centres where more complex cases are undertaken by people who do lots of them, rather than just a few a year. Results are better. This applies, for example, to vascular surgery, the treatment of stroke, to major trauma, and to cancer where 'networks' of specialists have been created across hospitals so that the routine treatment can be delivered locally but more complex and difficult cases are handled by those who specialise in such treatments in more specialised centres.

?only when lots of non-physicians are required

Meanwhile the European Working Time Directive<sup>1</sup> has restricted the hours that doctors in training can work, changing the nature of that training and the experience gained.

evidence for this being effective in training?

The medical workforce is also changing dramatically. Increasing numbers of women are entering medicine. Back in 2000, just 21% of UK consultants in all specialties were women. Today the figure is 46%. Well over half the intake of UK medical schools is now female. And among specialist registrars (qualified doctors who are undertaking their specialist training) three-quarters of the posts are now held by women. The full implications of what will soon be a female-dominated medical workforce are still not understood. Much will depend on future behaviour, which is far from entirely predictable. But it is more than likely that many women will take at least some time off work when they have families, and many may wish to work less than full time for part of their career. Furthermore there is appreciable evidence that men entering medicine now want the same opportunities for a more generous work-life balance and may be less committed to full-time working than their forebears.

85% of OBGYN residents are women; 95% of midwives, 95% of nurses and nurse extenders

All these changes apply as much to gynaecology and obstetrics – the care and treatment of women for specifically female diseases, and the medical care and treatment of women in pregnancy, childbirth and beyond – as they do to other forms of medicine. Combined they mean that the current pattern of provision of obstetrics and gynaecology is unsustainable.

New ways of providing the service, however, do offer potentially big gains in safety, quality, and access to care, and to the rewards of a medical career. But they have consequences for how and where care is provided.

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1 NHS Employers. European Working Time Directive. 2011  
[www.nhsemployers.org/PlanningYourWorkforce/MedicalWorkforce/EWTD/Pages/EWTD.aspx].

These changes combined are beginning to **tear apart the traditional model** by which health care is delivered in the UK.

Traditionally, GPs working in primary care have provided the vast majority of contacts between doctors and patients, with technology-driven diagnosis (from blood tests to scanners and X-ray) and subsequent secondary treatment all provided by the so-called district general hospital – a hospital with an accident and emergency department, and a maternity department, and in which pretty much the **full range of all but the most specialised services have been provided relatively locally.**

The new model that is emerging, to use the language of Lord Darzi's 2007 report on Healthcare for London,<sup>2</sup> is to 'localise where possible, **centralise where necessary**', doing so in the interests of quality, safety and convenience.

**Tried in NY 1990's perinatal transfers didn't work**

That means, however, that in future not all hospitals will provide the traditional full range of services. They will become more differentiated and specialised – some providing a full trauma and stroke service, for example, others providing only the more routine surgery and medicine and a minor injuries unit. More care will be provided out of hospitals, supported by the telephone, the internet, the electronic availability of records, and the ability to send diagnostic information from tests that patients themselves have conducted down the phone line or over the web: so-called telecare and telehealth.

The consequences of these changes do not flow all in one direction. In many areas they allow an extension of choice for patients over where, how and by whom they are treated. But for more specialised care the interests of quality and safety will dictate less choice. **If patients want the best outcomes, for some conditions they will have to travel further.**

**Cost shifting - no accounting for increased travel costs**

Quality, safety and access to the best possible care at the right time from the right person are the key drivers behind all this. But money also comes into play. In the wake of the financial crisis in 2008, the subsequent recession, and the creation of massive financial deficits as a result of rescuing the banks and other financial institutions, spending on health care across most of the industrialised world will be under huge pressure in the coming years.

In the UK, the need to deal with the deficit means that 7 years of feast in terms of growing expenditure on the National Health Service (NHS) are to be followed by 7 years of famine. A decade of record levels of growth in NHS spending is being followed – starting in 2010 – by at least 7 years in which there will be little or no real terms growth in NHS spending. Indeed, depending on what happens economically, by the end of the 7-year period and possibly beyond, there may even be real terms decline in expenditure.

The UK is not alone in that. But there is no escaping its implications. **Better value for money** (ideally, best value for money) in the way care is provided is now not just desirable but an absolute requirement – for clinicians who want to do the best job possible, for taxpayers who provide the cash, and for patients who will want the best possible service available when they need it.

There remains considerable debate over whether the changes outlined above will actually save significant sums. There is, however, some evidence that at least some of them can deliver better value in terms of quality and safety for the same expenditure.<sup>3</sup>

In England, there is the complicating factor of the Health and **Social Care Act 2012.**<sup>4</sup> The Act embeds the trend over the past two decades for the Government of the day to seek an **extension of competition and choice in the provision of health care** in the **belief** that this will drive up both efficiency and the quality of care. The purchase of services by the NHS is undergoing a major upheaval with **clinical commissioning groups** (CCGs) replacing primary care trusts and strategic health authorities. A new and statutorily independent National Commissioning Board will commission the more specialised services while also authorising and overseeing the CCGs. The Government has also introduced a new economic regulator in the shape of Monitor to ensure, as far as possible, a **level playing field** in the provision of NHS care

2 Darzi A. Healthcare for London: A Framework for Action. London: NHS London; 2007 [www.nhshistory.net/darzilondon.pdf].

3 Academy of Medical Royal Colleges. *The Benefits of Consultant-Delivered Care*. London: AoMRC; 2012 [www.aomrc.org.uk/item/benefits-of-consultant-delivered-care.html].

4 Health and Social Care Act 2012. c.7.

**really competition in insurance, not care- but 50% deliveries now Medicaid, no competition there are the measures providing care, or generating profit?**

between NHS organisations, the private and the voluntary sectors, with 'any qualified provider' now able to offer NHS care at NHS prices over a growing range of services. These changes too will have an impact over where and how care is provided, and on where and how specialists work. **2-tier Swiss system**

Over the past 2 years, the Royal College of Obstetricians and Gynaecologists has been considering the implications of all this for women and for the doctors who work in these specialties.

It has done so in a way that, for the College, is unique. It has not talked just to itself, its fellows and its members. It has sought oral and written evidence from women- and patients' organisations, involved specialist registrars in its deliberations and conducted a survey of women's views both in terms of what they desire and of how well they think services currently work. It has listened to patients' organisations such as National Voices, and to academics and healthcare managers not involved solely with obstetrics and gynaecology.

It has produced twin reports. *High Quality Women's Health Care: A proposal for change*,<sup>5</sup> published in July 2011, and *Tomorrow's Specialist*, published in September 2012. The latter, now released, has been drawn up under the guidance of Baroness Julia Cumberlege, the former health minister responsible for the Changing Childbirth policy, who chaired the Working Party, and Sir Cyril Chantler, the vice chair who is chairman of the Academic Health Science Partnership of University College London Partners.

*High Quality Women's Health Care*, chaired by the social policy academic Dame Joan Higgins, set out a radically different view of how obstetricians and gynaecologists should see their role. No longer should it be limited to the specific interventions they can provide at a given moment in a woman's life. Rather the profession, working in partnership with women, should see its task as supporting them across their lives. Individual doctors should seize every moment to promote healthy lifestyles and undertake preventive measures, from newborn child vaccinations, through chlamydia screening, preconception care, pregnancy and its aftermath, and on to the menopause, cancer screening, and across the many other occasions when disease may bring women into contact with obstetricians and gynaecologists.

**its not lifestyle but industrial food sources**

The College has dubbed this as supporting a 'life-course' approach to women's health care. One that promotes well being from the earliest years onwards. One that prepares women for what is to come. And one that ensures, as far as possible, that women receive the right care, at the right time, provided by the right person, in a way that not only produces the best possible clinical outcome but which provides a service that women are delighted with. Women's experience of their care – patient satisfaction – is an important part of this equation. It is not just the technical quality of care and the outcomes produced that matter.

Right now, that is not the case. Survey evidence collected by the *Tomorrow's Specialist* Working Party indicates that while obstetricians and gynaecologists believe that 80% of women are satisfied with the care they receive in their unit, just 54% of women say they have been satisfied with the care they receive. The surveys were not statistically rigorous, being designed to stimulate discussion within the Working Party. But they showed that there is a big gap – a big disconnect – between doctors- and women's perception of the care they receive. A 'salutary lesson' for the profession, as Dr Tony Falconer, the College President, puts it.

**they don't pay for it - and patient satisfaction with their cocaine supplier does not translate into healthy lifestyle**

Adopting a 'life-course' approach to women's health itself has big implications for obstetricians and gynaecologists. It is not something they alone can do. They by no means control all the levers to make this a success. Achieving this goal will mean working in teams. It will mean working with other clinicians – midwives, GPs, nurses, health visitors, specialists in women's health – while seeking to influence those involved with some of the broader determinants of health; those working in housing and social services, for example. It will mean working with charities and voluntary organisations who have an impact on women's lives, whether as a central part of their mission, or merely as part of it.

Combine this ambitious goal with the pressures outlined above and it is clear that not only will the way services are delivered have to change, but so too will the way obstetricians and gynaecologists work.

**replete examples that this is total BS- no eating disorder and drug abuse services to pregnant women. obesity services don't work changing centralized restrictions and requirements for breast screening. teen postpartum home visits not available**

5 Royal College of Obstetricians and Gynaecologists. *High Quality Women's Health Care: A proposal for change*. RCOG Working Party report. London: RCOG, 2011 [http://www.rcog.org.uk/high-quality-womens-health-care].

The majority of today's specialists (consultants) were essentially trained to work in a hospital-based system in which the consultant was the monarch. Consultants would be expected to be competent across the majority of situations involving both non-emergency and emergency obstetrics and gynaecology. Certainly for older consultants, the presumption was that once appointed they would be 'flying solo' in independent consultant practice for the remainder of their careers.

That concept has long been dying. It will soon receive the last rites. Indeed, almost 30 years after Dr John Hampton, the distinguished cardiologist wrote in the *British Medical Journal* that 'clinical freedom is dead', it is remarkable that even the idea of independent consultant practice lives on. Evidence shows that the solo practice as a consultant can lead to poorer safety, lower quality and worse outcomes in terms of patient care.<sup>6</sup>

Furthermore it is the College's absolute belief that for an obstetric delivery suite in particular a consultant presence is required 24 hours a day, 7 days a week, if mothers and their babies are to receive the best possible care. Consultant cover is also required for gynaecological emergencies. That is far from the case at present, despite the fact that consultant numbers have been expanding for a decade.

More than half of all births occur 'outside normal working hours' – at nights and weekends. Yet the vast majority of 'out-of-hours' medical care is provided by specialist registrars – qualified doctors who are, nonetheless, still completing their training as obstetricians and gynaecologists. Some such care is provided by staff, associate specialist and specialty grade doctors (SASGs) – fully qualified doctors who are not in a post that is likely to lead to a consultant appointment. Consultants are, of course, available. But in many cases they are merely 'on call' – available to provide advice or come in to the hospital if they judge the situation to be beyond a specialist registrar's expertise. It is clear, however, that does not provide the best possible care. The likelihood of fetal distress resulting in moderate or severe harm to the child, or even death, for example, is higher out-of-hours.<sup>7</sup>

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don't confuse training with already trained care

because have restricted and eliminated private physicians, mostly thru unsupportable credentialing requirements

Neither women, nor the profession, nor policy makers and those who commission care should accept this situation, which essentially presents women with a lottery, depending on when their child is born. Women clearly do not accept this. More than 80% in the survey conducted by the Working Party said they expected a specialist doctor to be present on the delivery suite 24 hours a day, and none disagreed that experienced midwives should be present.

ignoring the financials \$400/SVD

Consultants who provide night cover will, of course, need time off. But the requirement for 24-hour cover is just one example of how care across obstetrics and gynaecology is best delivered in teams.

evidence for this, and cost?

Other driving factors are that newly qualified consultants, partly because their hours of 'on the job' experience are lower, need mentoring and support from more experienced colleagues. In addition, working lives are lengthening. A newly qualified specialist is now likely to work for at least 30 and possibly as many as 40 years. The briefest of glances backwards to 30 years ago shows how far medicine and medical technology has changed in that time, and it is changing now at least as fast and quite possibly faster. So appointment as a specialist – as a consultant – is merely a step, although a crucial one, along a road of lifelong learning and adaptation.

no one is paying for training

Delivery of more care outside hospitals will require a more flexible workforce. Specialists will work in different locations: in the hospital, but also in the community. And they will work in 'networks' of specialism that cross hospital boundaries. That in turn will have implications for women over how and where care is provided.

US is moving outpatient care into the hospital campuses and satellites - offices are closing

Networks were first developed for cancer, more than a decade ago. In essence they involve the redesign of care so that it is focused on patients and services, rather than buildings and organisations. The path that

6 Health Care Team Effectiveness Project. *Team Working and Effectiveness in Health Care: Findings from the Health Care Team Effectiveness Project*. Aston Centre for Health Service Organisation Research, Aston University; Psychological Therapies Research Centre, University of Leeds; Human Communications Research Centre, University of Glasgow. 2002 [http://homepages.inf.ed.ac.uk/jeanc/DOH-glossy-brochure.pdf].

7 Royal College of Obstetricians and Gynaecologists. *Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour*. Appendix 5, p 69–71. London: RCOG, 2007 [http://www.rcog.org.uk/womens-health/clinical-guidance/safer-childbirth-minimum-standards-organisation-and-delivery-care-la].

patients take through the healthcare system is designed so that as much care as possible is delivered locally, while ensuring that the patients who require the most specialised intervention receive it in the right location and from those best equipped to provide it. Care thus crosses hospital boundaries, involves a range of professions and requires team working. By devising and adopting best practice, networks can advise commissioners on what they need to buy, and they should play a crucial role in auditing and benchmarking results. Networks can be relatively local. But they can also be a national way of organising services.

For cancer and stroke, that has demonstrably improved the quality of care and the health outcomes achieved. Some other networks, including that for care of the newborn – neonatology – have had a more difficult gestation, though not without success. Both the Government and the medical profession generally, however, are sufficiently convinced of the advantages of this for the new National Commissioning Board to have announced the intention to create a small number of national networks, one of which will include maternity and children's services.<sup>8</sup>

The College welcomes that but strongly believes – not least in the light of its report *High Quality Women's Health Care* – that the reach of the network should be much broader than just maternity and children's services. It would be better defined as a 'women's health network' so that it embraces, for example, gynaecological care outside child bearing age, so that the specialty is able to adopt the full 'life-course' approach to women's health outlined above and in last year's report from the College. **dilutes OBGYN focus**

Although the College in its twin reports is clear about the direction of travel, it is far from clear that the specialty itself is fully prepared for its implications. The survey of specialist registrars conducted by the Working Party showed that only 43% expected to move during their career. A third expected not to, with almost a quarter undecided whether that was likely to happen or not. Asked if they believed obstetricians and gynaecologists were likely to spend more time working outside hospital, only 57% of consultants believed that to be the case. Perhaps more worryingly, only 45% of specialist registrars accepted that they were likely to spend more time working outside the traditional hospital. As many as 42% did not believe that would happen.

So what are the implications of all this? The goal of a fully consultant-delivered service is an essential aim of the College. Fortunately the big expansion in medical school numbers since 2000 makes that achievable. The **number of doctors in training is to be cut back**. But as far as the College can judge, there are sufficient doctors already training in the specialty to achieve the goal of 24-hour consultant cover over the next decade, although only if significant changes are made in the way the service is organised.

**US says doesn't have enough and the ones we have are retiring**

Consultants, however, cost money. They earn more than doctors in training. The College's belief, however, is that the improved diagnosis and treatment that can result from the decisions of fully trained specialists will improve both the quality and the efficiency of care, helping to meet part of the affordability issue.

These consultants will work differently. They will work in teams. **Younger and less experienced consultants will be mentored by the more experienced** as they continue to learn and expand their expertise. Their roles and responsibilities will change over their careers. And they will work in networks, across hospitals and across the hospital, community and primary care divides. Indeed it is possible in time that specialists will be employed by networks rather than by individual hospitals. At the same time there will be more of the changes that had already started to occur where some services that used to be provided by consultants will be taken on by midwives and nurse specialists within the team – as has already happened with ultrasound scanning, outpatient hysteroscopy (examination of the inside of the womb), colposcopy (examination of the cervix or neck of the womb) and menopause services.

There will be **fewer acute obstetric units** – those that handle the most difficult cases of childbirth – with **more low-risk births taking place at home or in midwife-led units**. That is a result of twin drivers: the goal of achieving the highest possible quality care for high-risk cases, allied to the need to concentrate resources most efficiently. For some women, this will mean **care closer to home** and with a significant degree of choice over where they give birth. For others, it will, in the interests of quality and safety, mean that they have to travel further.

**2012 US CDC 10x and 3.9x increase for Apgar=0 at 5 mins at Home and Birthing Center Births compared to all comer Hospital Births**

8 NHS Commissioning Board. *The Way Forward: Strategic clinical networks*. NHS CBA, 2012 (<http://www.commissioningboard.nhs.uk/files/2012/07/way-forward-scn.pdf>).

**a contradiction - more regional centers means further from**

**in a private practice experienced physicians benefit from this. in a shared care, employed situation, there is no benefit especially if training low level providers. And menopause services are too complicated in this setting seeing multiple providers**

More service delivered by fully trained specialists, however, will mean less service being provided by specialist registrars. That will offer them the opportunity to spend more time learning, and less on routine service delivery. Training is anyway changing. Surgical and medical simulators offer high quality technical training in which doctors can learn with less risk to patients as they do so. **US is using LESS trained?**

That applies both to common procedures, but also to the less common where already there are worries that the **reduced hours spent in training are producing specialists who have not experienced the less common procedures in sufficient numbers.** **again- a contradiction and flaw in the plans- transforming specialists into administrative supervisors**

At present, while the European Working Time Directive<sup>9</sup> restricts the hours spent delivering the service, the time spent in training for obstetrics and gynaecology (7 years) is the longest in Europe. A reduced demand for routine service from specialist registrars, plus more intense training, plus technological advances in how training is delivered, plus a more specialist-delivered service, not to mention already planned cuts in the numbers of doctors entering specialist training, clearly implies either fewer registrars, or the possibility of a shorter training period, or both.

The precise length of time spent in training is not a matter solely for the College. Others, including the General Medical Council, also have oversight of that.

But fewer registrars in return for more consultant posts, and/or shorter training, could and indeed should help significantly with the issue of affording a much more consultant-delivered service. In addition, as a more specialised service is delivered, the improvements in quality and safety that should follow should lead to lower insurance premiums for clinical negligence and mishaps.

In this changed world, it will also be **important that all specialists during their training are equipped with the essential skills to understand and participate in research.** As in other areas of medicine, it is from research that advances in treatment come. Amid longer working lives and an ever increasing speed of technological change, it is essential that the specialists of the future can live in and adapt to that world. A shorter period of more intensive training, allied to the acquisition of the necessary academic skills, would see specialists appointed to their first substantive post younger – certainly by their early thirties – and when they are likely to be at their most creative. **saps resources from clinical care demanding more from clinicians**

They will, nonetheless, work as part of a team within which they will continue to learn from more experienced colleagues. In other words, these changes do nothing to create a 'sub-consultant' grade of doctor. Indeed, over time, as this agenda is fulfilled, it is likely that the requirement for staff, associate specialist and specialty grade doctors (SASGs) will decline.

What the changes do imply, however, is continued lifelong learning and development for specialists, with the role they play within teams changing over time as their experience and skills grow.

For doctors, **this is an exciting agenda.** But it should bring big advantages to women's health care as well. After all, that is what it is designed to do. It should provide higher quality care delivered in a more flexible and more preventative framework in which women themselves can take greater responsibility for their care and be supported in so doing. There will be some changes, however, that are likely to be less popular but which need to be faced. **evidence?**

Smaller, **more isolated maternity units are likely to close or become midwife-led units.** As services are linked across networks, more travel will be involved for the treatment of some conditions. The case for this will need to be made locally, with local political support sought, and the case for such changes will need to be clearly explained if the reshaping of services is not to face repeated challenges and delay. **again, further travel for services**

The College cannot achieve this vision alone. Those responsible for medical education, health care employers, the commissioners of care and politicians all have a part to play.

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<sup>9</sup> NHS Employers. European Working Time Directive. 2011  
[www.nhsemployers.org/PlanningYourWorkforce/MedicalWorkforce/EWTD/Pages/EWTD.aspx].

There is action the College itself can take, however. It should itself reassess the length of training required as these changes take effect, review the curriculum, develop mentoring schemes for newly qualified specialists, and help design the new patterns of service (and the justification for them) that commissioners need to purchase. It should ensure that the curriculum includes the necessary elements of academic training, and training in personal and professional skills, alongside the clinical content. Crucially too it needs to formalise continuing professional development once a specialist has qualified, developing an accredited programme of training and experience that will in turn help doctors cope with the demands of revalidation.

The College is convinced that if the recommendations in its twin reports are adopted, the result will be both a better, safer, more preventative service for women across their lifetimes, and a more varied and stimulating career for doctors in the specialty of obstetrics and gynaecology. This is an exciting, challenging and rewarding prospectus that needs to be realised.



**Nicholas Timmins** was public policy editor at the Financial Times between 1996 and 2012. He now works part-time at The King's Fund as a senior fellow for health policy. He has written extensively on public and private health care over the years and has worked on a number of reports, including *The future of leadership and management in the NHS: No more heroes*.

Nick is also a senior fellow at the Institute for Government, a senior associate of the Nuffield Trust, and a visiting professor in public management at King's College London and in social policy at the London School of Economics. He is an honorary fellow of the Royal College of Physicians, and was president of the Social Policy Association between 2008–11.

Nick's most recent book is *Never Again? The story of the Health and Social Care Act 2012*, published in July 2012.

