

# Working Together

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The Society of Obstetricians and Gynaecologists of Canada (SOGC) is the oldest society devoted to obstetrics and gynaecology in North America. It is recognized, both here and abroad, as a leader in women's health. Our continuous education programs, guidelines, and numerous projects have advanced our specialty in Canada and abroad. My predecessors as SOGC President have included some of the most influential and brilliant specialists in women's health, and they have set the bar high. Their legacy is the myriad of important and vital projects of the SOGC, and our stakeholders are among the most important people in our lives. They are the women we look after as patients, and the women and families around the world for whom we can be a voice and take action.

A few years ago I wrote an editorial in JOGC about an interesting phenomenon in our line of work. It is a feeling that we are never really sure if we're "there" yet. When you are a student or a resident, you pass examinations and you graduate. You move on to the next year. There is defined progress. Then you become a "real doctor" in practice, and suddenly the finish line has disappeared. There is always more to do and more to be done. You can choose to be overwhelmed by the possibilities, restrict your practice, refuse to contribute as a volunteer, and wear blinders to the rest of the world. Or you can choose to be overwhelmed by the work to be done, and run faster on the treadmill with a constant sense that you're not quite doing enough. Fortunately, there is a third option. You can realize that none of us can accomplish great things alone—that even the smallest of contributions, in the right context, may lead to great things when it is synergized with the work of others.

The SOGC was built by physicians who recognized that they could do more together than they could alone. We are strong today because of the hundreds of volunteers who donate their time and energy to writing guidelines, attending teleconferences and committee meetings, and developing continuing education programs and attending them. We learn from each other, recognizing that our greatest

contributions are made when we work with other specialties, with other disciplines, and with the women we ultimately serve. Virtually all of our committees now involve specialists, family doctors, and nurses. The MORE<sup>OB</sup> program, our quality improvement program in obstetrics, is centred on a team approach to the delivery of care. And we work with our junior fellows to address the needs of an upcoming generation of practitioners—a generation that will need to know so many things and to master so many tools that simply learning the essentials presents a daunting task. Without question, working in teams will be the norm, and accepting that one person cannot do it all is their reality. Some will choose general obstetrics and gynaecology, and they will refer complex cases to others, who in turn will focus on areas they will master. Some will teach at all levels, while others will spend time in the lab, and yet others will travel to remote areas to cover consultations for underserved populations. These choices will enrich our specialty, and all are equally important. Students and residents are our future and they deserve our attention and time. Many of us have likely not thought about the Hippocratic Oath since our medical school graduation. To remind you, the first paragraph after "I will keep this Oath" is as follows: "To reckon all who have taught me this art equally dear to me as my parents and in the same spirit and dedication to impart knowledge of the art of medicine to others. I will keep abreast of advances in medicine."

Who does not remember the voice and words of a supervisor, a staff consultant, who influenced us with their actions and their wisdom? It may have been in surgery, or at 2:00 a.m. in the middle of a delivery, but years later you find yourself in a similar situation, mimicking their response. It is the professional equivalent of the classic line: "Suddenly it hit me: I have now become my mother." We all have mentors we are happy to emulate in our work. One of my heroes was Ray Lee, at the Mayo Clinic in Rochester. Ray dedicated his famous atlas of gynaecologic surgery not to his family or his staff but to the women who trusted him enough to let him operate on them. His priority was never to lose sight of the women and families who are the reason we do what we do. The SOGC shares this view. It is expressed in our

mission statement: “To promote excellence in the practice of obstetrics and gynaecology and to advance the health of women through leadership, advocacy, collaboration, outreach and education.”

Last year, the SOGC renewed its strategic plan and adopted a revised mission statement. This renewal process was the product of an extensive consultation with our Council, with community members, with key decision makers, and with our members. We outlined seven strategic directions that would guide the work of the Society from 2006 to 2011: Aboriginal health, advocacy, continuous professional learning, human resources, international women’s health, patient safety, and women’s health issues. Each of these strategic directions is critically important to women’s health, but I would like to highlight two that are particularly close to my heart.

The first—human resources—bridges several of our strategic directions. We know that one person cannot do it all. But, in some communities, one person may be all they have. How can we address this reality? This question alone has ramifications in our key directions of continuous professional learning, advocacy, and patient safety.

The specialty of obstetrics and gynaecology was defined in Canada sixty years ago. In 1946, the Royal College asked the President of the SOGC to recommend members who could lead a committee for a specialty that was previously lumped in with surgery. Now there are three subspecialties recognized by the Royal College, as well as a burgeoning field of other subspecialties. For example, there are now at least five different approaches to hysterectomy. We’re even starting to use robots. Every year we have newer and better techniques. The maternal-fetal specialists are constantly updating the recommended screening in pregnancy, and ultrasound has reached a fourth dimension.

We must ensure that appropriate new technologies are introduced safely into our armamentarium. The moral imperative is clear: we must push forward as a specialty, lest the women of Canada be denied the best techniques and the best caregivers possible. But how do we accomplish this on top of busy practices—on top of teaching commitments and administrative responsibilities? It is time to revisit our ability to work as a team so that we can meet these goals, but there will be no uniform solution. A model that will work in a large academic centre, where everyone has their niche, will not work in remote communities. Ultimately, we all must prioritize. We must be prepared to ask difficult questions, such as:

- What can we relinquish?
- How can we work with our colleagues, peers, and partners to bring out the best in ourselves?

- And how can we optimize the available resources to meet the clinical and academic needs of our community?

Together, we must build a shared vision of where we are, where we are going, and how we will get there. This vision will influence our ability to recruit and retain the best of clinicians and researchers, physicians, nurses, and midwives. It will also define our ability to lead in obstetrics and gynaecology internationally.

Our growth will depend on our capacity to evaluate our challenges, to adapt our training and expectations, and to advocate for our needs. The SOGC is well positioned in this regard. The collaborative maternity care project established partnerships that will help us advance and advocate new models of care delivery. In the coming year, the SOGC will carry out a workforce survey. This survey will provide critical information to help identify our challenges and to plot the path forward.

The second of our strategic directions that is very close to my heart is our commitment to international women’s health. I attended the assembly of FIGO in Malaysia last fall. It was truly remarkable to witness this international gathering of leaders in our specialty openly recognizing SOGC’s contributions to FIGO and to women’s health around the world. As a relatively small society, SOGC devised the first junior fellow programs in 1994. We led three of the 12 funded projects in the Save the Mothers and Newborns initiative. It was also a great source of pride to witness the inauguration of an SOGC Past President, Dr Dorothy Shaw, as the new President of FIGO. That day, Dr Shaw became only the second Canadian and the first woman ever appointed to the position.

Today, my appreciation and understanding of the SOGC’s international work continues to develop. In March, I was invited to participate in the first International Leadership Workshop for Young Health Professionals in Kampala, Uganda. We’ve all heard the statistics about maternal mortality in developing countries, and the numbers are shocking. But when you visit the country, these people are not just numbers any more—they become individuals. There is no running water in most local health facilities. In the national referral hospital, 60 babies a day are delivered, although the hospital was built to house one third of that number. Women deliver on the floor. They walk in with ruptured uteruses and convulse with eclampsia. They wait for their Caesarean sections because there is no anaesthetic drug available. For a Canadian witnessing this, the feelings can be overwhelming.

But then you meet some of the nurses, midwives, and physicians who work in that environment. These people have decided to make the best of these adverse conditions. They

have managed to reduce risk and influence change. For me, it was impossible to walk away without an enormous sense of the privilege I have somehow inherited, simply by being born in Canada. And I assure you, there are lessons we can all learn from our colleagues in developing countries, who have shown courage and determination while working in conditions we can barely imagine. In return, we can share some of the lessons we have learned about improving care here in Canada.

This year SOGC is committed to projects with four countries: Guatemala, Uganda, Haiti, and Burkina Faso. Over the past decade, many of our members have volunteered in these countries, and we continue to sponsor ALARM courses and other initiatives in these and other countries. The SOGC commits a portion of the annual budget to international efforts, and I recognize now more than ever the contributions of the visionaries supporting these projects.

These countries are not on a different planet. They are a plane ride away. And the people who live in them all seek

the same things that we do: healthy families, a place to work and earn a living, and a safe place to live and enjoy the things we have. At the end of the day, most of us hope to have made a positive difference in the world. And I can think of few, if any, nobler contributions than saving the lives of mothers around the world.

As an organization, and as a profession, we will face challenges ahead. But these challenges should not be faced alone. We have learned from our Aboriginal population that it takes a village to raise a child. Well, SOGC is our village, and the child we are raising is the promotion of excellence in obstetrics and gynaecology and the advancement of women's health, both here and abroad. I am very proud to be involved.

*This editorial is based on the Incoming President's Address, delivered by Dr Lefebvre at the Annual Clinical Meeting of the Society of Obstetricians and Gynaecologists of Canada in Ottawa, June 25, 2007.*