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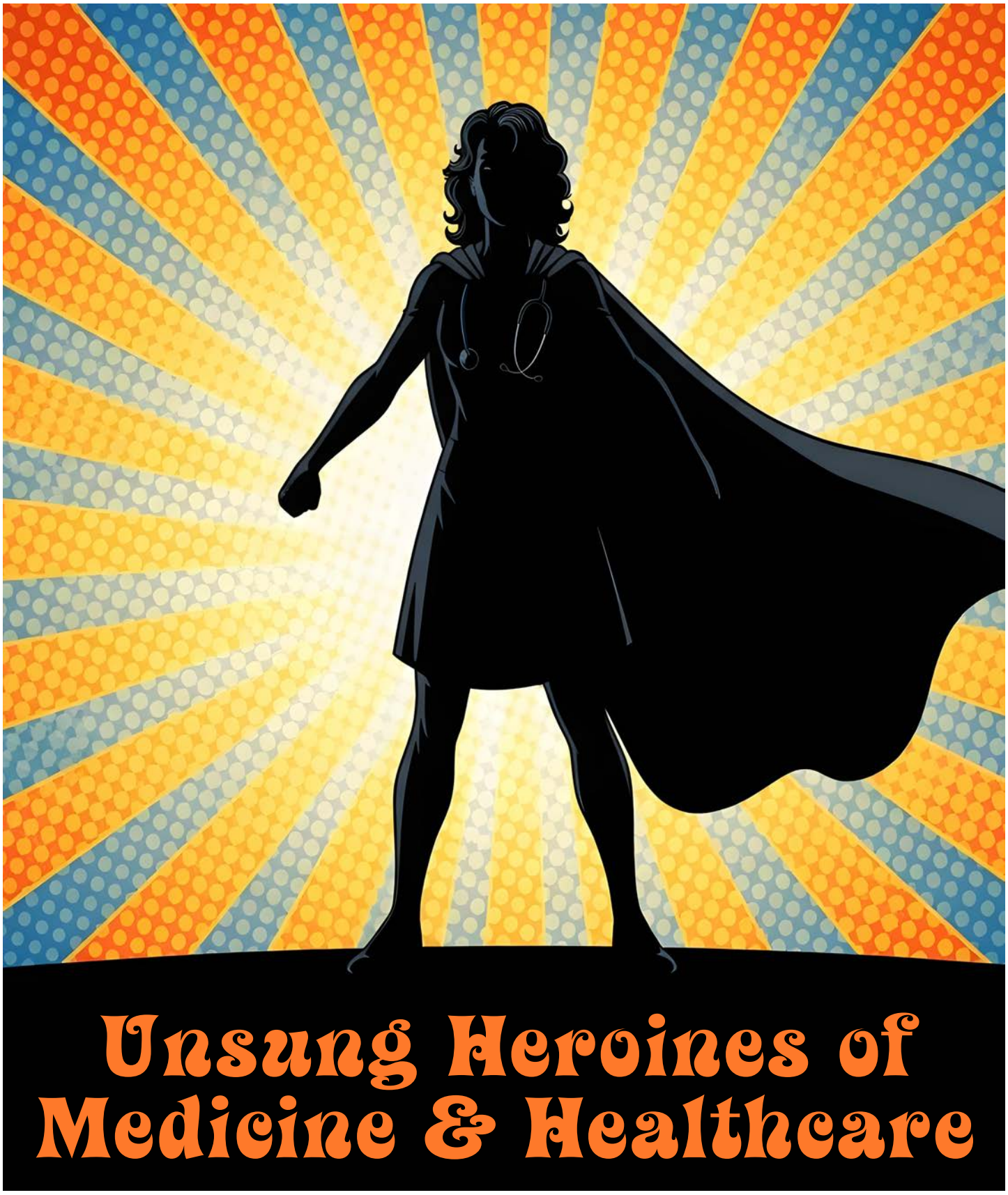

Unsung Heroines of Medicine & Healthcare

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In this Issue...

We Need to Dig Deeper for Ovarian Cancer

By Sue Claridge with Liz Pennington

Ruby Smith, a young Northland mother of three young children, died from ovarian cancer on Waitangi Day this year.[1] She was only 32 when she was diagnosed with stage 3 ovarian cancer, a disease that in Aotearoa New Zealand has a five-year survival rate of 42.8%*.[2] Ruby's specific type — mucinous ovarian cancer — has a five-year survival rate of just 25%.[1]

Ruby's death is devastating for her whānau and friends. It is also a poignantly sad loss for the Ovarian Cancer Foundation New Zealand (OCFNZ).

On May the 25th 2025 – World Ovarian Cancer Day — Ruby gifted her song *Dig Deeper* to OCFNZ,[1] and this year she became the face of the OCFNZ *State of Ovarian Cancer Report Aotearoa New Zealand 2025*[2] with her photo on the cover. It must have been agonising for the OCFNZ team to have learned of Ruby's death only the day before their report was launched at Parliament.[3]

OCFNZ wrote online:

> ***"Ruby was an extraordinary young woman with a deep love for her family, music, and adventures. Even through the hardest moments of her cancer journey, Ruby chose love, courage, and hope. She made a conscious decision to turn pain into her superpower, to keep looking outward and caring about others, even when life was at its heaviest."***

> ***"Ruby used her voice to advocate for women facing ovarian cancer. Her message was simple but powerful, trust your instincts, ask questions, and fight for answers. She believed in standing up for yourself and for others, and she carried that belief into everything she did."***

They acknowledged Ruby's gifts to, and advocacy for, the Foundation and promised to honour her legacy.

Ruby Smith's death puts a painfully personal face on the devastation wrought by ovarian cancer in Aotearoa New Zealand. There is an average of 306 new diagnoses each year, and one woman dies every 48 hours; 30% of women diagnosed die in the first year.[2] But it is not just the numbers that are so awful; behind the statistics are woman/wāhine who:

- have been to their doctor with symptoms multiple times before they are diagnosed;
- have waited years to be diagnosed;
- have become so sick that their cancer is diagnosed as a result of a visit to the emergency department†;
- who have felt isolated and overwhelmed by their diagnosis and treatment journey;
- who know that there is not enough research to prevent this happening to many hundreds more New Zealand women/wāhine in the future.

* in contrast, the five-year survival rate for breast cancer in Aotearoa New Zealand is 87%.

† 48% of women are diagnosed through emergency or unplanned hospital admissions.[2]

The State of Ovarian Cancer in Aotearoa Report

The OCFNZ *State of Ovarian Cancer in Aotearoa Report* is a vitally important document. While more women in Aotearoa New Zealand are diagnosed with breast cancer, and more die, the awareness of breast cancer is much, much higher, and the survival outcomes are much better. More women survive breast cancer as a proportion of those diagnosed, than survive ovarian cancer. "As the leading cause of gynaecological cancer death, ovarian cancer takes the lives of more women than allother gynaecological cancers combined, including cervical cancer"[2] even though cervical cancer garners far more publicity and funding within our health system.

It is important for women/wāhine and their doctors to have a greater understanding of the impact of ovarian cancer. It is important for policy and decision makers to have a greater understanding of the systemic failures in Aotearoa New Zealand that ensure that ovarian cancer has such poor outcomes compared with other cancers. There needs to be better education, greater awareness, more research, earlier diagnosis and better treatment.

What the Ovarian Cancer Foundation Want You to Know

Liz Pennington, General Manager of OCFNZ, shared some of the most important parts of the *State of Ovarian Cancer in Aotearoa Report* with AWHC ahead of the launch of the report at Parliament.

The report is informed by three surveys OCFNZ undertook in 2025: a survey of the public, a survey of GPs and health practitioners; and a survey of women with lived experience. The report is centred and strongly focussed on women's lived experience and their voices are found throughout the report.

A 2021 Te Aho o Te Kahu report found that research into ovarian cancer was significantly underfunded in

Key insights

- Early diagnosis can save or extend lives.
- Emergency presentation doubles the one-year mortality.
- There are persistent inequities for wāhine Māori and Pasifika, with higher rates of emergency diagnosis, rare ovarian cancer diagnoses and younger ages at diagnosis.
- New Zealand lags behind Australia in research and clinical trial access. Greater investment and equity are urgently needed to improve survival outcomes.

Aotearoa New Zealand relative to its mortality rate compared with other cancers. Since the publication of the National Ovarian Cancer Report in 2022, the Health Research Council has modestly increased funding for ovarian cancer research.[4]

New Zealand women/wāhine have significantly less access to clinical trials compared with those in Australia; only five clinical trials are available in Aotearoa New Zealand while there are 44 in Australia.

> ***"It's easy to talk about the need for more research and yes, we need it! But what women really need right now is support that feels human. Clear pathways, honest conversations, and care that meets us where we are. Awareness has to go beyond symptoms; it has to include what it means to truly live with ovarian cancer."***
>
> *— Ruby Smith*

Women/wāhine are willing to courageously share their stories in the hope that it will be better for others. They saw research and access to clinical trials as key to better care and finding a cure. Women were also very clear that ovarian cancer pathways need to be connected at all points on the journey and that the way in which they received information, updates about care and results mattered a great deal, as did how they received that information. Many wrestled with constant "what ifs…." and "if onlys". These thoughts are described as intrusive at times and affect women's mental health while they are trying to move forward. There was a strong sense that it can be better than it is now.

What is needed to transform outcomes

These actions reflect what will truly shift the needle for ovarian cancer outcomes in Aotearoa:

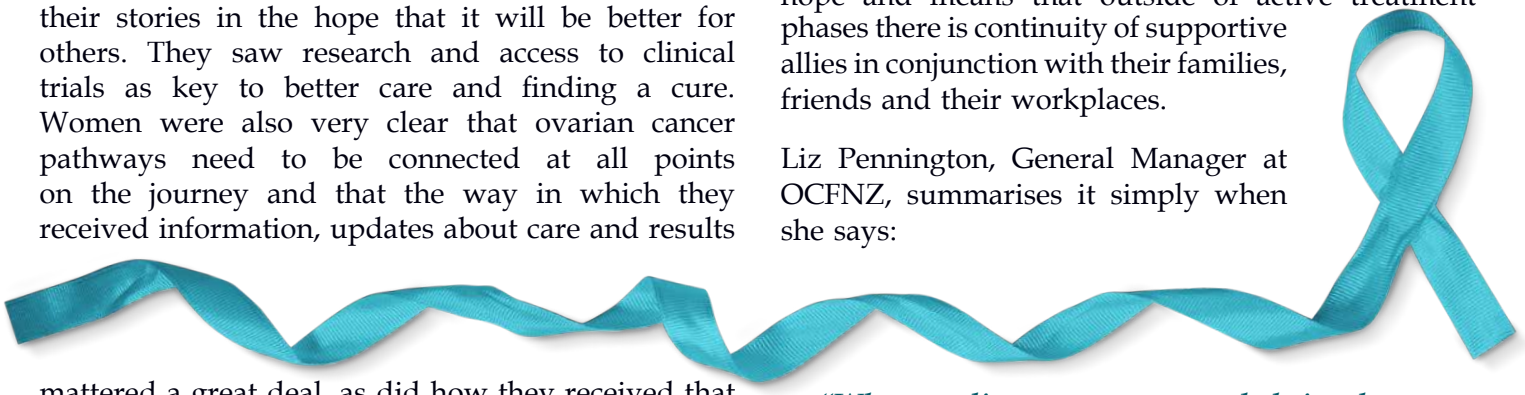
- Reduce the incidence of emergency diagnosis.
- Add ovarian cancer symptoms education to the national cervical screening programme and clarify that screening does not detect other gynaecological cancers.
- Amend Health Pathways to allow GPs to refer symptomatic women for an ultrasound at their first GP visit.
- Address data gaps and make accurate, real-time data more accessible across the health system.
- Prioritise ovarian cancer clinical trials.
- Increase funding and focus on ovarian cancer by the Health Research Council of Aotearoa New Zealand.
- Improve medicines access and investment.
- Include people with lived experience, their whānau and patient advocacy groups in service design, policy and research.

Hope sat at the forefront of women's perspectives and OCFNZ heard that the support of other wāhine mattered.

> ***"Peer groups help a great deal to support"***
>
> *— OCFNZ lived experience survey*

Women want to feel empowered to make choices; to do all that they can, day-to-day, to support their treatment; and to build understanding and knowledge while engaging with support from others with lived experience. Ongoing peer-support instils hope and means that outside of active treatment phases there is continuity of supportive allies in conjunction with their families, friends and their workplaces.

Liz Pennington, General Manager at OCFNZ, summarises it simply when she says:



> ***"When we listen to women and their whānau as a community, really listen to them, we can't simply unhear it, we can't unsee it and we certainly can't unknow it. The time for change is now and the case for change is utterly compelling".***

References

1. Piper D, 2026: Northland mum and ovarian cancer advocate Ruby Smith dies after three-year fight, *New Zealand Herald*, 10 February 2026.
2. OCFNZ, 2026: *State of Ovarian Cancer Report Aotearoa New Zealand | He kōrero mo te ahuatanga o te mate pukupuku kākano-ā-kopu ki Aotearoa*, Ovarian Cancer Foundation New Zealand.
3. OCFNZ, 2026: State of Ovarian Cancer in Aotearoa New Zealand 2025, Video of Parliamentary Launch, 11 February 2026.
4. Claridge S, 2024: Killer Cancer Flies under the Radar, *Auckland Women's Health Council Newsletter*, February-March 2024; pp 8-21.
5. OCFNZ, 2025: 2025 Ovarian Cancer grants awarded, OCFNZ News, Research, Ovarian Cacncer Foundation New Zealand, 17 December 2025.

OCFNZ Putting Their Money Where Their Mouth Is

In their *State of Ovarian Cancer in Aotearoa Report*[2], OCFNZ pointed out that the research funding for ovarian cancer in Aotearoa New Zealand is dire. Ovarian cancer research is typically underfundedby the Health Research Council (HRC) in New Zealand compared to 13 other cancers supported by the HRC.[4] It is one of the least researched cancers, both nationally and internationally, considerably slowing progress with diagnosing and treating the disease.[2]

OCFNZ's mission is to improve ovarian cancer today while funding transformational research to find tomorrow's cure.[2]

> *"OCFNZ invests in transformational research that delivers real impact for women living with ovarian cancer. In the last two years, we have funded more research than ever before, supporting both established and emerging researchers here in Aotearoa. Through a partnership with the Cancer Research Trust (CRT), OCFNZ is the largest ovarian cancer research funder in New Zealand, we ensure every dollar that we commit to research drives discovery, innovation, and equity."*[2]

In October 2025, OCFNZ held two major fundraisers: the Long Lunch, hosted in Auckland on October 3 raised over $90,000, and the month-long Frocktober campaign with over 200 participants raised over $145,000.[5] These events resulted in an amazing fundraising total of $235,000. At the end of the year OCFNZ announced the recipients of the 2025 ovarian cancer grants.

The major research grant was awarded to Dr Qi Chen, Associate Professor in the Department of Obstetrics and Gynaecology at the University of Auckland. Dr Chen's research searches for ways to stop the growth of ovarian tumours by investigating how placental extracellular vesicles (tiny, balloon-like structures that can carry messages between cells) can alter the body's own immune response. Dr Chen said:

"With an overall lower survival rate, more effective therapies for ovarian cancer are urgently needed. Receiving this award empowers us to develop a novel approach for ovarian cancer treatment that utilises natural production as an immune modulator."

To support researchers to strengthen research capability OCFNZ are also funding two international travel grants, which provide funding so early career researchers can visit an international laboratory. These visits will facilitate stronger global co-operation, and expose researchers to new ideas and techniques that they can bring back to Aotearoa New Zealand.

Rosa Latton of the University of Otago has been awarded one travel grant; she intends to travel to the UK to spend time in Dr Robb Hollis' lab to explore profiling and genotypic analysis of low-grade serous ovarian cancer. Katie Walker, also of the University of Otago, will be travelling to Australia to work with world-renowned researcher Dr Anna DeFazio.[5]

Congratulations to not only the grant recipients, but also all the amazing New Zealanders who raised funds so that the OCFNZ had the funds to support vital research that will make a difference to the women/wāhine of Aotearoa New Zealand.

Katie Walker

Dr Qi Chen

Rosa Latton

International Women's Day

8 March 2026

Unsung Heroines of Medicine & Healthcare

By Sue Claridge

For centuries, science and medicine developed within deeply patriarchal and sexist societies that systematically excluded women through formal barriers and cultural norms. Universities, medical schools, and scientific societies either barred women outright or admitted them only as exceptions, while prevailing beliefs framed women as intellectually inferior, emotionally unstable, or biologically unsuited to rigorous study.

Even when women demonstrated aptitude and intelligence, their work was frequently dismissed, published under male names, attributed to male colleagues, or confined to "acceptable" areas such as nursing, midwifery, or domestic health. Legal restrictions, lack of financial independence, and social expectations around marriage and motherhood further constrained women's participation in scientific life and medicine.

Yet despite these obstacles, women refused to be silenced or erased. They pursued education wherever cracks appeared in the system, lectured publicly when institutions shut their doors, published radical critiques of male-dominated knowledge, and challenged the assumption that objectivity belonged only to men. By insisting on their right to study, practice, and theorise, these women not only advanced science and medicine themselves but also exposed how power and gender shaped what counted as legitimate knowledge, laying essential foundations for gender equity in health and science today.

To celebrate International Women's Day 2026, we take a look at the almost hidden, sometimes forgotten contribution women have made to medical science, women's health and gender equity, by focussing on the lives and work of some extraordinary women, without whom our lives and the world of science and medicine most certainly would be poorer.

Antoinette Brown Blackwell

We start with Antoinette Brown Blackwell, a pioneer for science, women's rights, and gender equity. Born in 1825 in New York state, Antoinette is famous for becoming the first woman in the United States to be ordained by a recognised denomination. However, she makes it into this article as the woman who challenged Charles Darwin's sexism. Her first published work was *Studies in General Science* (1869), a copy of which she sent to Darwin. In a letter replying to her, Darwin addressed her as "Dear Sir," revealing the gender assumptions prevalent in science at the time.[1]

Antionette did not react, did not correct Darwin's error, but she didn't forgive or forget either.

In 1871, Darwin published *The Descent of Man*, and *Selection in Relation to Sex*, in which he argued that evolution had made men intellectually superior to women. His contemporary, social scientist Herbert Spencer, stated that in order for the human race to flourish, women must devote their lives to reproduction.[1]

Antoinette Blackwell had already spent much of her life promoting women's equality and found Darwin and Spencer's views unacceptable.[1]

Four years after Darwin's books were published, Antoinette published her most influential scientific work, *The Sexes Throughout Nature* (1875), which represented a groundbreaking critique of the male-centric interpretations of evolution advanced by Darwin and Spencer. In contrast to Darwin's assertions of male superiority, Antoinette argued that the sexes are different but fundamentally equivalent in evolutionary value. By dissecting examples from plants, animals, and humans, she demonstrated that previous scientific conclusions were shaped by gender bias and that women's distinct qualities deserved full recognition in scientific analysis. Her argument was not just scientific but philosophical: only women could fully articulate the nature of female experience in the biological sciences, because men inherently viewed the world through a masculine lens.[1, 2] She wrote that male scientists stood on:

> *"a learned masculine eminence, looking from their isolated male standpoints through their men's spectacles and through the misty atmosphere of entailed hereditary glamour."*

Although her approach would not meet modern scientific standards, Antoinette Blackwell's work was among the earliest feminist engagements with scientific theory, challenging the idea that science

was a neutral, male-only enterprise and insisting that intellectual rigor should be decoupled from gender.

Aside from her direct attack on the sexism of scientists of the time through her writing, Antoinette was a formidable activist. She participated in early women's rights conventions, helped found organisations like the Association for the Advancement of Women, and served in leadership roles within suffrage groups.[1]

A trailblazer in science and the struggle for gender equity, Antoinette Blackwell shattered barriers that confined women to domestic duties, and laid the intellectual groundwork for later feminist thought. Throughout her long life, she married deep religious conviction with critical engagement in science and social reform, advancing an expansive vision of equality long before such ideas gained widespread acceptance.

Mary Putnam Jacobi

Mary Putnam Jacobi was a physician, educator, writer, and feminist whose tireless efforts transformed women's position within the medical profession and reshaped broader understandings of women's health.

At a time when women were widely considered too delicate or intellectually inferior for serious scientific

work, Mary Jacobi leveraged rigorous research, steadfast advocacy, and institutional leadership to challenge myths about female biology, expand women's access to medical education, and advance gender equity within medicine and society at large. In particular, she debunked prevailing menstruation myths.

Born in London in 1842 and raised in the United States, Mary Jacobi's intellect and early life observations drew her to medical training at a time when formal opportunities for women were severely limited.[3] She became the first woman in the United States to earn a pharmacy degree, graduating from the New York College of Pharmacy before completing her medical degree at the Female Medical College of Pennsylvania in 1864, one of the only institutions at the time that admitted women. Determined to further her medical training she travelled to Paris and became the first woman admitted to the École de Médecine of the University of Paris, graduating in 1871.[3, 4]

Back in the United States, Mary distinguished herself as a physician and educator. Not only did she maintain a thriving clinical practice in New York City, but she also joined the faculty of the Women's Medical College of the New York Infirmary for Women and Children. The medical education available to women was still inadequate compared to that offered to men, so, in 1872, Mary founded the Association for the Advancement of the Medical Education of Women and served as its president for decades. Under her leadership, this organisation championed equal educational standards, organised improved clinical training for female students, and pressed for women's acceptance into mainstream medical institutions.[3, 4]

Integral to Jacobi's legacy was her groundbreaking research into women's physiology, especially menstruation, at a time when misinformation about the female body was used to justify educational and professional exclusion.

Girgis and Ganti write that "During the 1870s, prevailing research from Harvard faculty on menstruation proposed that women were impaired by the process and required rest throughout the duration of the cycle."[3]

One Harvard professor, Dr Edward Clark, argued that "girls never be allowed to study more than four hours per day, separate from boys, and take every fourth week off entirely lest they become infertile and even devolve into a theoretical third gender that he called "agene" and compared to sexless termites."[4]

In 1876 Mary Jacobi entered the prestigious Harvard


Dr Mary Jacobi

Boylston Medical Prize competition with her essay *The Question of Rest for Women During Menstruation**, a meticulously researched study based on extensive physiological data and surveys of hundreds of women.[3] Rather than supporting the prevailing assumption that menstruation incapacitated women and warranted special rest, Mary demonstrated that there was no basis for such claims, proving that women's biology did not preclude intellectual effort or rigorous work. The essay won the prize, shocking many male judges when they learned it had been written by a woman.

Mary Jacobi wrote extensively, producing more than 120 medical articles and nine books covering paediatrics, pathology, neurology, medical education, among other subjects, and consistently integrating rigorous scientific method with a belief in women's equal capabilities.[5] In challenging medical and cultural assumptions about female biology, she not only advanced medical knowledge

* Dr Mary Putnam Jacobi's essay, eventually published as a book *The Question of Rest for Women During Menstruation*, can be accessed online.

but also provided intellectual ammunition against arguments used to deny women access to education and professional lives.

Mary Putnam Jacobi's legacy continues in today's medical schools, research laboratories, and in women's health. Her commitment to women's rights and gender equality was "a major contributor to the freedom that modern-day women experience."[3] She proved that women were as capable of scientific research as men and that menstruation was no impediment to education, work or a scientific or medical career. She contributed to the dismantling of scientifically unfounded barriers, established institutions to support women's education, and centred women's health as a domain for serious inquiry.

Dr Marthe Gautier

In the late 1950s, French physician and researcher, Marthe Gautier, discovered the link between Down Syndrome and chromosomal abnormalities, and was forced to stand back and watch as a male researcher took credit for her milestone discovery.

In May 1958, at a time when cytogenetics was just emerging, Dr Marthe Gautier made a ground-breaking observation: cells from a boy with Down syndrome carried an abnormal number of chromosomes.[6] Marthe's meticulous work in establishing in-vitro cell cultures under primitive conditions allowed her to count human chromosomes. Working at *Hôpital Armand-Trousseau* in Paris, she repeatedly counted 47 chromosomes in the sample cells from the Down syndrome boy; the first solid evidence that this condition was caused by an extra chromosome.[7]

Her discovery established the genetic cause of Down syndrome, trisomy 21, a milestone that ultimately transformed research, diagnostics, and care for affected children and their families. Recognition of trisomy 21 opened the door to prenatal testing and reshaped how the medical community understood chromosomal abnormalities.[7]

At the time Marthe discovered the 47 chromosomes in the cells she was studying through the microscope, her laboratory lacked the equipment to photograph what she saw. A younger colleague, Jérôme Lejeune, offered to take her slides and get them photographed. She never saw them again.[8, 9]

Six months later she was shocked to find that her discovery was about to be published with Lejeune listed as the first author, Gautier second (with her name misspelled), and Raymond Turpin (the head of the research team) last, the order implying that Lejeune had done the most important work. Over time, Lejeune became widely known as "the discoverer" of trisomy 21, while Gautier's crucial contributions were overlooked.[6, 7]

For decades, Gautier remained largely silent as Lejeune took the credit for her discovery. Disgusted by what had happened, she returned to clinical work and paediatric cardiology. But as the years passed, she became increasingly frustrated by the historical narrative that excluded her. On the 50th anniversary of the discovery in 2009, she published an article recounting her role and challenging the accepted account.[7, 9]

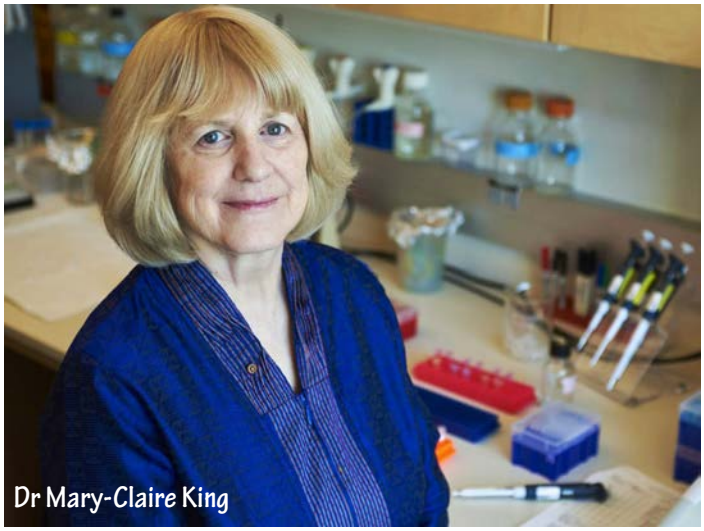
Her struggle for recognition highlighted broader issues of gender and credit in science, a modern example of the "Matilda Effect," where women's contributions are neglected or attributed to male colleagues.

Dr Marthe Gautier with her French Legion of Honour medal

In 2014, the French ethics committee of *INSERM* formally acknowledged her essential role, and in her later years the French government honoured her scientific achievements. Gautier died in 2022 at age 96, finally remembered for her part in one of the most important discoveries of 20th century genetics.[10]

Dr Mary-Claire King

Dr Mary-Claire King is one of the most influential geneticists of the late 20th and early 21st centuries, whose work transformed the understanding of hereditary breast and ovarian cancer, and reshaped modern genetic medicine. Her landmark discovery of the *BRCA1* gene provided the first clear genetic explanation for inherited breast cancer risk and laid


Dr Mary-Claire King

the foundation for cancer risk assessment, prevention, and precision medicine.

In the 1970s, the dominant theory for the cause of breast cancer was that it was triggered by a viral infection.[11] However, Mary-Claire King began investigating why certain families had unusually high rates of breast cancer, a pattern that could not be fully explained by lifestyle or environment. Her hypothesis — that a single gene mutation could account for many cases of early-onset hereditary breast cancer — was initially met with scepticism by the scientific community.[12] Combining rigorous statistical analysis with painstaking family studies, she spent more than 15 years mapping cancer patterns across generations. In 1990, Mary-Claire King and her colleagues identified a region on chromosome 17 strongly linked to hereditary breast cancer, providing decisive evidence that a major susceptibility gene existed. This gene was later named BRCA1.[13, 14]

The implications of this discovery were profound. Women carrying pathogenic *BRCA1* variants were found to face dramatically increased lifetime risks of breast and ovarian cancer. Mary-Claire's work transformed cancer genetics from a theoretical discipline into a clinical tool, enabling predictive genetic testing and targeted surveillance strategies. Today, *BRCA1* testing informs decisions about screening, preventive surgery, and treatment, saving lives all over the world.

Beyond the laboratory, Mary-Claire has been a powerful advocate for the ethical application of genetic science. She championed the use of *BRCA* testing for population-wide screening, particularly among groups with higher prevalence of mutations, such as Ashkenazi Jewish communities. Her approach emphasised informed consent, equitable access, and the prevention of genetic discrimination.[11, 15]

Her contributions extend far beyond cancer genetics. She has applied genetic methods to human rights investigations, including identifying children stolen during Argentina's military dictatorship and confirming family relationships in war crimes cases.[16]

Mary-Claire King's career exemplifies science in service of humanity. By uncovering the genetic roots of hereditary breast cancer, she changed medical practice, empowered patients with knowledge, and set enduring standards for the ethical use of genetic information.

Dr Katie Hind

For decades, scientific understanding of human breast milk was limited largely to its basic nutritional components. Researchers treated it merely as a source of calories, fat, and protein — the vital factors needed to sustain infant growth.

Lactation expert and researcher, Associate Professor Katie Hinde says, "Scientists know more about what's in a tomato than what's in human milk."[17] In reviewing existing research, she found that there are more scientific papers on tomatoes, coffee and wine than on breastmilk; there are twice as many scientific studies on erectile dysfunction as on breastmilk.[18]

However, her work has started to redress the balance and has revolutionised our understanding of what breastmilk is, its composition and what it actually does, demonstrating that breastmilk is a dynamic and highly adaptive biological fluid tailored to the needs of individual infants.[19]

Katie's research, particularly in rhesus macaques, revealed that the composition of milk changes systematically depending on the sex of the infant. Mothers produced milk richer in fat and protein for sons, supporting rapid growth in muscle and size, while milk for daughters tends to contain more calcium and larger volumes, aligning with different developmental trajectories.[20] Importantly, this sex-


Dr Katie Hinde

specific variation suggests that milk serves not just nutritional but evolutionary developmental roles that start at the very earliest stages of life.

Beyond sex differences, Katie's research has shown that milk composition continues to change over the course of lactation and even within a single day. The nutrient and bioactive molecule content of milk, including hormones and immune factors, adjusts as infants age to support changing developmental needs. Moreover, breast milk contains hundreds of human milk oligosaccharides — complex sugars that babies cannot digest but that feed beneficial gut bacteria and help protect against harmful pathogens.[17, 18, 20, 21]

Another groundbreaking insight from Katie's work is how breastmilk responds to infant health states. There is evidence that immune components like antibodies fluctuate with maternal and infant exposures to infection, acting not just as passive protectors but as responsive elements tuned to current threats.

Dr Katie Hinde's research changed everything: "milk wasn't passive. It was a message."[21] A conversation. A dialogue between mother, infant and the environment in which they live. Her research showed just how responsive mother's milk is, responding within hours to the information that is exchanged in that dialogue.

"The mechanism [is] remarkable: when a baby nurses, small amounts of the baby's saliva travel back through the nipple into the mother's breast tissue. That saliva contains information about the baby's immune status. If the baby is fighting an infection, the mother's body detects the antigens and begins producing specific antibodies, which then flow back to the baby through the milk."[21]

Katie Hinde's research has shown how critically important breastfeeding is, and why everything must be done to support mothers to breastfeed, rather than to be led towards the one-size fits all fake milk marketed as a perfectly adequate alternative.

"We need to recognise that too often historical traumas and implicit biases sit in the space between a new mother and her clinician. The body is political. If our breastfeeding support is not intersectional, it is not good enough."[18]

Dr Katie Hinde's work has opened new horizons in understanding milk as not just food, but food that *communicates* with the infant, shaping growth, immunity, metabolism, and even behaviour. Her work underscores that milk is far more than nutrition: it is a biological dialogue between mother and child — adaptive, responsive, and deeply personalised — and only just beginning to be understood by science.

References

1. Rubin R, 2017: The Woman Who Challenged Darwin's Sexism, *Smithsonian Magazine*, 9 November 2017.
2. Murphy JS, 1991: Antoinette Brown Blackwell. In: Waithe, M.E. (eds) *A History of Women Philosophers*, vol 3. Springer, Dordrecht.
3. Girgis KN & Ganti L, 2024: Dr Mary Putnam Jacobi (1842-1906): The Pioneer of Women's Medical Education, *Cureus*. 2024 Sep 10;16(9): e69081.
4. Tyra A, 2025: Mary Putnam Jacobi, National Women's History Museum, 2025.
5. WIMLF, 2022: Dr Mary Putnam Jacobi: Releasing Women From the Prison of Their Own Bodies, Women in Medicine Legacy Foundation, 9 August 2022.
6. Pain E, 2014: After More Than 50 Years, a Dispute Over Down Syndrome Discovery, *Science Now*; 343 (6172): 720.
7. Galliot L & McNulty S, 2025: Who Discovered the Cause of Down Syndrome? Lost Women of Science Podcast and transcript, *Scientific American*, 6 February 2025.
8. Fleming N, 2014: Who really decoded Down's syndrome? *New Scientist*, 2 April 2014.
9. Galliot L & McNulty S, 2025: This Researcher Discovered the Cause of Down Syndrome, But For 50 Years Got None of the Credit, Lost Women of Science Podcast and transcript, *Scientific American*, 13 February 2025.
10. Thoman LM & Batut J, 2026: Four women whose pioneering contributions to science have been largely overlooked, *Elife*. 2026 Feb 11:15:e110644.
11. Dreifus C, 2015: A Never-Ending Genetic Quest, *New York Times*, 9 February 2015.
12. A Trailblazing Geneticist Reflects On Her Life And Work, Podcast and transcript, *Science Friday*, 16 September 2025.
13. Batt S, 1994: *Patient No More: The Politics of Breast Cancer*, Ragweed Press / Gynergy Books.
14. Miki Y, et al., 1994: A strong candidate for the breast and ovarian cancer susceptibility gene BRCA1, *Science*. 1994 Oct 7;266(5182):66-71.
15. Shute N, 2014: How Being Ignored Helped A Woman Discover The Breast Cancer Gene, *All Things Considered,* NPR; 27 March 2014.
16. Zhu M, 2017: Mary-Claire King, Embryo Project Encyclopedia, 23 August 2017.
17. Yarrow A, 2018: Why do we understand so little about breastfeeding? *The Washington Post*, 21 February 2018.
18. Hinde K, 2016: What we don't know about mother's milk, TEDWomen, October 2016.
19. AAUW, 2023: The Science of Mother's Milk with Dr. Katie Hinde, AAUW Seattle Branch, 30 January 2023.
20. Bock E, 2016: Breast Milk Is 'Liquid Gold' for Infants, Hinde Says, NIH Record, 22 April 2016; LXVII, No. 9.
21. Philipp B, 2025: Leaders in Lactation: Dr. Katie Hinde, The Lactation College on Substack, 2 December 2025.

Celebrating our Wāhine Toa

Two Trailblazers in Medicine in Aotearoa New Zealand

Continuing our theme for celebrating International Women's Day, this Celebrating our Wāhine Toa column looks at two amazing women, the first two women doctors to train and graduate in New Zealand: Dr Emily Seideberg and Dr Margaret Barnett Cruickshank.

In the late 19th century, when medicine was dominated by men, and women's roles were often constrained by societal expectations, Emily Hancock Siedeberg and Margaret Barnett Cruickshank were true trailblazers.

Dr Emily Siedeberg

Dr Emily Hancock Siedeberg, Aotearoa New Zealand's first woman to graduate in medicine, not only transformed clinical practice but also challenged social expectations of women in the late 19th and early 20th centuries.

Emily was born in February 1873 and grew up in Dunedin, where her father encouraged her education and ambition, instilling in her from an early age the belief that she should train as a doctor.[1]

After leaving Otago Girls' High School where she demonstrated academic excellence, in 1891 Emily became the first woman to enrol at the Otago Medical School at a time when female medical students were rare in the British Empire.[2] Although it was not technically difficult for her to enrol, she faced reluctance from Dean Professor John Scott and hospital medical staff.[1] Ultimately, both Otago University and hospital staff voted in favour of Emily being admitted.[3]

Despite this, the Dean's "attitude to women in his classes [gave] an impression of forbearance rather than enthusiasm."[2] For a time Professor Scott re-

Emily Siedeberg at her graduation in 1896.

fused to allow her to attend two of his anatomy classes with the men and taught her separately. A laboratory assistant at the time, "Wullie" Goodlet, commented that Emily had "a very unpleasant time" with her classmates:[2]

> "They did not want lady doctors and the lady students have to thank Miss Siedeberg for her pluck in making way for them."[2]

In 1896, Emily's perseverance was rewarded when she graduated with her Bachelor of Medicine and Bachelor of Surgery (MBChB), becoming the first female medical graduate in Aotearoa New Zealand.[1] This achievement was not just symbolic; it opened the doors to medical practice for other women and challenged deeply entrenched gender norms in professional life.

Following graduation, Emily briefly worked at the Seacliff Lunatic Asylum, before travelling overseas to further her medical training. She studied obstetrics, gynaecology, and children's diseases in Dublin and furthered her training in Berlin. In 1912 she also pursued postgraduate study in Edinburgh.[1]

On returning to New Zealand in 1898, with the support of her father Emily established a private general practice in Dunedin, which she continued for three decades. Her clinical work was both broad and innovative. In 1905, she was appointed medical superintendent of St. Helens Hospital, a government funded maternity hospital in Dunedin. She remained in this role until the hospital's closure in 1938, earning respect as a leader in women's health care.[1]

Emily helped establish New Zealand's first antenatal clinic in 1918, a forward-looking initiative that emphasised preventive care and structured support for pregnant women. Her work with midwives and close collaboration with the Plunket Society further cemented her impact on maternal and infant health care.[1] While still working at St Helen's Maternity Hospital, in 1921 Emily also began a 10 year career as anaesthetist at the Dunedin Dental School.[3]

Beyond her clinical contributions, Emily Siedeberg was deeply involved in wider community and welfare organisations. She was a foundation member of the Dunedin branch of the New Zealand Society for the Protection of Women and Children in 1899 and remained actively engaged throughout her life.[1, 4] She was a foundation member of the Otago University Women's Association, the New Zealand Federation of University Women, and the Townswomen's Guild. She also served as a delegate to the first Pan-Pacific Women's Conference


Dr Emily Siedeberg, 1873-1968

and was a central figure in the *National Council of Women of New Zealand*.[4]

Perhaps Emily Siedeberg's most enduring institutional legacy was her role in founding the New Zealand Medical Women's Association in 1921.[5] By bringing women doctors together, she helped create a professional network that promoted women's interests, fostered collaboration, and supported the next generations of medical practitioners.

Emily Siedeberg received numerous honours, including life memberships with the New Zealand Branch of the British Medical Association (1929) and the New Zealand Registered Nurses' Association (1939). In 1935 she was awarded the King George V Silver Jubilee Medal, and in 1949 she was appointed Commander of the Order of the British Empire (CBE) for services to medicine and the welfare of women.[4]

Dr Emily Siedeberg died in Oamaru on the 13th of June 1968 at the age of 95, after a lifetime of contributions that reshaped both health care and the role of women as doctors. Her house in York Place, Dunedin, once both home and practice, is now recognised as a Category I Historic Place, affirming her national significance.[4]

Emily's graduation as the first New Zealand woman with a medical degree occurred only three years after the women of New Zealand were given the vote. Today, thousands of women practice medicine

across the country. Many walk paths first cleared by Dr Siedeberg, whose courage and vision broadened opportunities for women in health and whose efforts improved the wellbeing of women and children across the nation. In celebrating her as a wāhine toa, we acknowledge a woman whose contributions continue to shape health care and gender equity more than century on.

Dr Margaret Cruickshank

In 1896, Dr Margaret Cruickshank was only the second woman in New Zealand to complete a medical degree and the first woman to be registered as a doctor in New Zealand — a formal recognition that allowed her to practise medicine independently.

Margaret and her twin sister, Christina, were born on the 1st of January, 1873, in Palmerston, Otago. The girls were only ten years old when their mother died, after which the sisters shared the responsibilities of caring for their five younger siblings, alternating days between schooling and household duties.[6] Each evening the twin who had attended school taught her sister what she had learnt that day.[7] This early experience shaped Margaret's resilience and commitment to service, traits that would define her life's work.

Academically gifted, Margaret attended Otago Girls' High School, where she and Christina were joint duxes in 1891.[7] Margaret gained a University Junior Scholarship and, on the advice of a teacher, followed her friend, Emily Siedeberg into medicine at the University of Otago Medical School,[6] then one of the few institutions in the Southern Hemisphere that admitted women to medical training.

Margaret Cruickshank at her graduation in 1897.

In 1897, Margaret graduated with an MBChB one year behind Emily, becoming the second woman in New Zealand to complete a medical degree.[8] On the 3rd of May 1897, she achieved an historic milestone by becoming the first registered woman doctor in Aotearoa New Zealand,[6] and the first to practice.[8]

Margaret's first position was as assistant to Dr Herbert Barclay in the small South Canterbury town of Waimate, where she would spend the rest of her career and life in service to the community, becoming a partner in the practice in 1900.[8] From the outset, she demonstrated not only clinical competence but deep compassion. Her practice was wide-ranging: she provided general medical care, assisted in surgery, attended births, and often travelled long distances, by horseback, bicycle, or on foot, to reach patients in remote rural areas.

In 1903, Margaret returned to medical school and obtained her Doctor of Medicine (MD) and in 1913 completed postgraduate studies in Edinburgh and Dublin.[8]

In addition to her clinical work, Margaret believed strongly in public education and health promotion. She offered first-aid classes through the local St John's Ambulance, teaching life-saving skills that extended the reach of health care beyond her own consultation room.

When World War I broke out, and with Dr Barclay enlisting and serving overseas, she took on the full burden of the medical practice and shared responsibility with two other doctors as superintendent at the local hospital. She also organised the local work of the Waimate Red Cross Fund,[6, 8] mobilising community resources to support the war effort and those affected by the conflict.[8]

When the 1918 influenza pandemic broke out, Margaret's dedication to her work and the people of Waimate reached new heights. As the epidemic ravaged the town, she worked day and night, often beyond the bounds of her professional duties, tending to the sick and dying. In many cases, her care extended to basic domestic tasks that families could no longer manage: feeding infants, preparing meals, and even milking cows to ensure nourishment for children.[6, 8]

Unfortunately, the extraordinary workload, and close contact with patients sick with the flu, took their toll on Margaret and she contracted the disease. Already

worn down by the immense physical and emotional toll of the pandemic, she succumbed to pneumonia on 28 November 1918, at the age of 45.[8]

Dr Cruickshank's death plunged the town of Waimate into mourning. Despite the pandemic, the streets were lined with residents as her funeral procession passed, a testament to the high esteem in which she was held. In 1922, the community commemorated her remarkable life by erecting a statue in Seddon Square inscribed with the words: *"The Beloved Physician – Faithful unto Death"*. It was the first statue erected to a woman in New Zealand other than Queen Victoria, underscoring her extraordinary legacy.[8]

> *"We wish that, in years to be, the story should be told of a woman who was brave, and strong, and kind, and true as steel, who had a heart with room for others' sorrows, and hands swift and sure in deeds of loving service; who gave her life as truly for duty's sake as any soldier on the "gallant, glorious" field. She is dead, but her influence on others is a living thing that cannot die."*
>
> – E. Morrison, 1924[8]

References

1. Sargison P: Biography: Siedeberg, Emily Hancock, as published on Te Ara, The Encyclopaedia of New Zealand; first published in 1996 in the *Dictionary of New Zealand Biography*.
2. Page D, 2008: The first women medical students at Otago, *Otago Daily Times*, 30 August 2008; excerpted from *Anatomy of a Medical School - A History of Medicine at the University of Otago 1875-2000*.
3. Geoffery Kaye Museum, 2017: The great women of anaesthesia: Emily Hancock Siedeberg McKinnon, 8 June 2017.
4. Emily Hancock Siedeberg-McKinnon, *The Early Medical Women of New Zealand: Stories from graduates 1896 – 1967*, University of Auckland; 9 March 2021.
5. Anderson K: New Zealand Medical Women's Association, published online in New Zealand History; first published in *Women Together: a History of Women's Organisations in New Zealand* (1993).
6. Hughes B: Biography: Cruickshank, Margaret Barnet, as published on Te Ara, The Encyclopaedia of New Zealand; first published in 1996 in the *Dictionary of New Zealand Biography*.
7. Margaret Cruickshank, Manatū Taonga — Ministry for Culture and Heritage, updated 2-Jul-2024.
8. Margaret Barnett Cruickshank, *The Early Medical Women of New Zealand: Stories from graduates 1896 – 1967*, University of Auckland; 26 April 2021.

AWHC

Annual General Meeting

The Auckland's Women's Health Council AGM will be held at **7pm** on **Thursday the 26th of March 2026** online via Zoom.

If you are interested in attending the AGM please RSVP by email to receive further details and the Zoom link.

awhc@womenshealthcouncil.org.nz

NZ's Desperate Need for a Patient Safety Commissioner has Been Ignored

By Sue Claridge†

Too many New Zealanders are being harmed by the very healthcare and medical treatment that they rely on to improve their health and wellbeing. There is currently no authority or agency specifically tasked with addressing patient harm in a proactive and responsive way that would reduce preventable harm in our health system.

These were the main findings of the Health Consumer Advocacy Alliance in 2023 when they set about researching and analysing patient harm in Aotearoa New Zealand and risk of harm reporting. That work, started almost three years ago, culminated in the publication of the discussion paper *Are Our Medical Harm Reporting Systems Effective? Are People Safe?*[1]

In releasing the discussion paper, HCAA said:

"Too many people have been harmed or have died due to intractable systemic failures that have not been properly addressed for decades. Robust harm reporting systems ensure that patients are kept safe. However, there is no evidence at all that patient harm is being identified and successfully monitored, with explicit action taken to stop harm when it occurs and to prevent further harm. While some medical harm is being reported there is no consistency in what is being reported, and these reports seem to disappear into the ether, with no transparency regarding follow-up and action. This is exacerbated by a failure of all health entities to identify and track practitioners who are repeat offenders in causing harm to multiple patients. No-one in Aotearoa New Zealand is competently tracking individual practitioner harm."[2]

The most significant recommendation of HCAA's discussion paper was the establishment of a National Patient Safety Commissioner "who would focus on preventing patient harm by: truly representing and giving weight to the consumer voice; analysing the structure of the health system and the reporting systems and improving the way in which medical harm is reported and acted upon; and providing a "fence at the top of the cliff" that would reduce the incidence of medical injury and harm."

Following the release of the report, HCAA launched a Parliamentary petition requesting that an independent Patient Safety Commissioner be established; the petition was presented to MPs at Parliament on the 27th of June 2024. HCAA engaged with and gained the support of a wide range of consumers, consumer advocates and organisations, including AWHC, and many in the health workforce.

HCAA made a number of written submissions to the Health Select Committee in support of the petition, which included letters of support from Patient Voice Aotearoa and the Cartwright Collective; Terry Taylor, Past President of New Zealand Institute of Medical Laboratory Science (NZIMLS); and Anne Daniels a registered nurse and President of the NZNO*. HCAA presented oral submissions to the Health Select Committee (HSC) on the 19th of February 2025.

The submissions to the HSC were part of a wider campaign by HCAA to ensure that preventable harm in our health system is properly addressed.[3, 4] The personal cost and the economic cost is too high; we simply can't afford not to reduce preventable harm to New Zealanders through health care and medical treatment.

Five hundred and thirty-nine days after HCCA's petition requesting the establishment of an independent patient safety commissioner was tabled in Parliament; 420 days after HCAA submitted their major written submissions (the first of eight written submissions); and 302 days after HCAA appeared in person in front of the Health Select Committee

† Sue Claridge is a co-founder and former Trustee of the Health Consumer Advocacy Alliance.

* the letter was Ms Daniels' personal support and did not represent the NZNO.

to make their oral submissions, the Health Select Committee finally submitted their report to Parliament.

On the 18th of December 2025.

Seven days before Christmas.

The report was underwhelming at best. The HSC "acknowledged" the HCAA's concerns. The HSC "hoped" that the Health and Disability Commissioner and other health sector entities "will help address systemic issues in the health sector." The HSC "hoped" to see strengthened advocacy and im-proved healthcare services for patients, whānau, and staff.

The HSC made ***no*** actual recommendations. It ***did not*** offer any practical response to the serious issue of preventable, avoidable harm caused to New Zealanders within the health system.

HCAA believe that the HSC has failed on multiple fronts to address the accountability gaps that place patients, whānau, and health staff at ongoing risk. Despite the evidence provided to the HSC – a Parliamentary body charged with ensuring accountability in the health system and with shaping legislation to improve health outcomes – it has concluded that when it comes to ensuring the safety of New Zealanders in our health system, there is nothing they need do except leave it in the hands of agencies that have, to date, failed to properly address preventable harm.

The $$$ Cost of Preventable Harm in Aotearoa New Zealand

A 2022 OECD report found that unsafe care results in well over three million deaths each year world-wide and that the health burden of harm is estimated at 64 million Disability-Adjusted Life Years (DALYs) a year, similar to that of road injuries.[5]

"In developed countries, the direct cost of treating patients who have been harmed during their care approaches 13% of health spending. Excluding safety lapses that may not be preventable puts this figure at 8.7% of health expenditure."[5]

In New Zealand, the 2025/26 health budget is $32.7 billion. Based on the OECD figure of 8.7% (above) for developed countries, we spend $2.8 billion per year just treating New Zealanders who have suffered ***preventable*** harm in the health system.

References

1. Korte C, Astill D, Gibbons K & Claridge S, 2023: *Are our Medical Harm Reporting Systems Effective? Are People Safe?* Discussion Document, 17 October 2023. Health Consumer Advocacy Alliance; Aotearoa New Zealand.
2. HCAA, 2023: Facing up to the reality of medical harm in Aotearoa New Zealand, Health Consumer Advocacy Alliance website (accessed 5 February 2026).
3. Claridge S, 2025: Keeping Patient Safety on the Agenda, *Auckland Women's Health Council Newsletter,* September 2025; pp 18-19.
4. Claridge S, Korte C, Astil D & Manley E, 2025: The HCAA Campaign to Adress Patient Safety, *Auckland Women's Health Council Newsletter,* September 2025; pp 19-21.
5. Slawomirsk L and Klazinga N, 2022: *The Economics of Patient Safety: From Analysis to Action*, Health Working Paper No. 145, Directorate for Employment, Labour and Social Affairs Health Committee; OECD.

Health Select Committee's Plan: Cross Fingers And Hope!

By the Health Consumer Advocacy Alliance

HCAA's petition to Parliament focused squarely on patient safety.* The Health Committee's final report, now released, fails on multiple fronts to address the accountability gaps that place patients, whānau, and health staff at ongoing risk. It accepts unsubstantiated assurances at face value, sidesteps structural failures, and avoids confronting clear evidence that the system remains reactive, opaque, and incapable of preventing repeat harm.

While acknowledging ongoing systemic issues, the report treats existing inter-agency arrangements as sufficient, leaving those failures largely unchallenged. There is no mechanism for consumers to raise concerns about the conduct, performance, or failures of New Zealand's oversight bodies and

* HCAA Website: written submissions in support of the Parliamentary petition.

health entities themselves. The Committee ultimately concludes by saying it merely "hopes" existing agencies will address these issues, while making no recommendations whatsoever. This exposes a failure far deeper than patient safety alone: the absence of any credible, independent oversight of the system itself.

The Committee states: ***"We hope that the work of the Health and Disability Commissioner and [other health sector entities]... will help address systemic issues in the health sector."***

Hope, however, is not accountability. Promises of future regulatory reform are accepted without challenge, despite repeated and well-documented failures. Workforce safety is largely ignored, and the system's persistent inability to learn from past harm continues to allow preventable failures to recur.

Although the Committee acknowledges serious problems, it proposes no action to address them. This approach amounts to little more than crossing fingers and hoping for improvement, a response that risks further eroding public confidence in the Parliamentary process.

Oversight remains embedded within the very system it is meant to scrutinise, undermining transparency, learning, and sustained improvement. The consequences extend beyond patient safety, affecting equity, access to care, workforce wellbeing, and overall quality of care. Submitted evidence is dismissed, contradictions over independence between the Ministry of Health and the Health and Disability Commissioner go unexamined, and the report offers no explanation for how meaningful system improvement could be sustained across political cycles without independent parliamentary oversight.

Ending the report by stating that the Committee "hopes" existing agencies will address systemic issues is an abdication of Parliamentary responsibility.

Transparency, independence, and visibility are not optional; they are foundational to a safe health system!

This failure is precisely why HCAA launched its petition: to demand independent oversight and real accountability. Patients, whānau, and health staff deserve a system that intervenes before harm occurs, learns from failure, and can be held to account when it does not.

The Health Select Committee has acknowledged systemic issues. How will "hope" address system failures?

10 Key Issues Overlooked in the Health Committee Report

In a system marked by ongoing, preventable harm, reliance on hope is not just inadequate, it represents an abdication of accountability. This failure to act is exactly why the petition was launched, to call for independent oversight and real accountability where the system has repeatedly failed those it is meant to protect.

1. The report fails to address the absence of any mechanism for consumers to raise concerns about the health bodies that are currently positioned as having oversight of the system, which leaves our Health Entities effectively unaccountable.
2. While the report acknowledges that unintentional

and preventable harm continues to occur, it fails to respond meaningfully to overwhelming evidence that patients and health staff face ongoing, preventable harm.

3. The report treats existing agencies as operating proactively, despite evidence that significant interventions typically occur only after serious harm, sustained public pressure, or media exposure.
4. Contradictory statements from the Ministry of Health and the HDC about their independence are not examined, undermining confidence in current accountability claims.
5. Without independent oversight, health system improvements remain vulnerable to shifting political priorities, organisational restructures, and changes in ministerial focus.
6. Assertions that feedback and restorative practices are improving are accepted without evidence, despite the absence of a national restorative framework.
7. The claims in the report of 'system strengthening' completely overlooks the significant voids in consumer engagement across the health system, especially localised engagement that is genuinely consumer-led, the learning capability of the health system as a whole, and the massive cuts in experience of our existing workforce.
8. Reliance on the National Quality Forum is untested in practice, with no scrutiny of its transparency, effectiveness, auditing, or independence.
9. The report accepts future regulatory reform promises as sufficient, despite repeated failures and reversals, including over reliance on outdated medicines and unregulated devices still causing harm.
10. Workforce safety concerns are still not being properly addressed, despite evidence that clinicians and health staff fear speaking up and lack effective, independent escalation.

The team at the Health Consumer Advocacy Alliance is passionate about incorporating restorative practice and a human-factors, relational approach across health care settings. Frameworks like the Healing, Learning and Improving from Harm: National Adverse Events Policy 2023 provide a vital platform for restorative practice while improving patient safety. Implementing this approach requires training and support; for restorative practice to succeed it must be visible and understood. The Health Consumer Advocacy Alliance fully supports this vital work and acknowledges the leadership and commitment of the team at Te Tāhū Hauora | Health Quality & Safety Commission. This framework will help to foster real, system-wide learning and safer care for all New Zealanders.

Responding appropriately to harm is as important as preventing it. Achieving this depends on a skilled, supported workforce, able to learn meaningfully from every adverse event. Currently this framework is not in place nationally, however, it is starting to be embedded. The HCAA feel it should be made available to all those who need it. Ongoing, targeted investment is essential to ensure it is applied consistently and accessible to all.

Women Suffer More Harm in Healthcare!

By Sue Claridge

As women/wāhine, we should be — ***must be*** — horrified at the blasé attitude of the Health Select Committee and its failure to do more than hope that our existing health entities will address the ongoing systemic issues that lead to thousands of New Zealanders suffering medical injury and harm in our health system every single year.

Medical injury and harm in our health system takes many forms, but there is no doubt that women are disproportionately impacted by avoidable, preventable harm. It is not a coincidence that the report that led to the establishment of England's Patient Safety Commissioner — widely known as the Cumberlege report[1] — reviewed the harm caused by primidos* and sodium valproate† used during pregnancy, and pelvic mesh — products that primarily affected women.

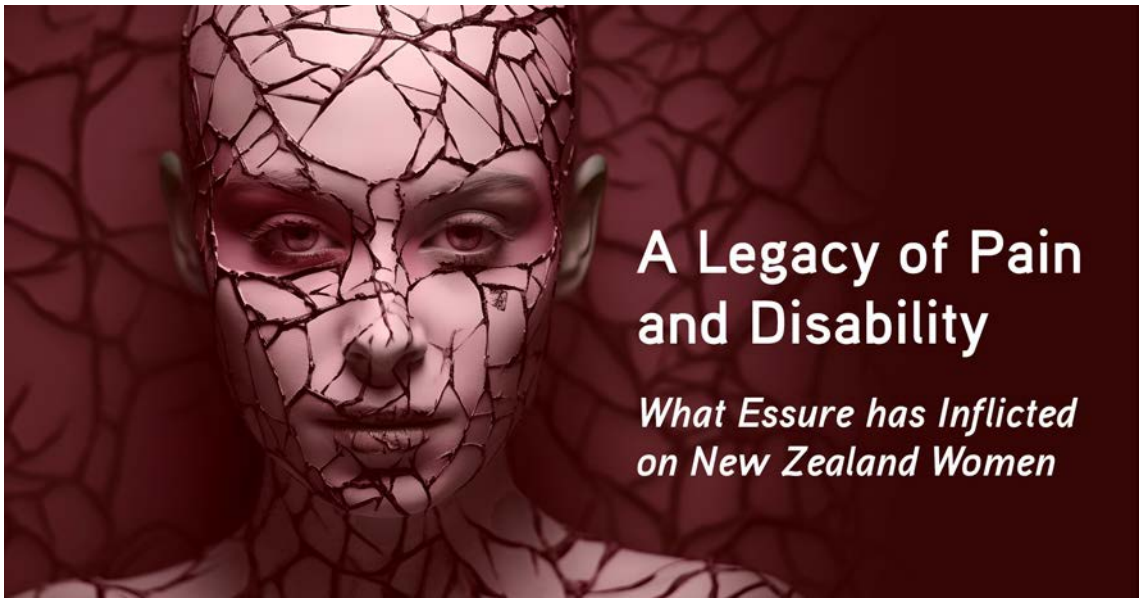
Over the last nine years of working for the Auckland Women's Health Council, I have spoken to many women who have suffered harm in our health system, often devastating and life changing harm, including those caused by medical devices, drugs, surgery, underdiagnosis or incorrect diagnosis, diagnostic delays, and gender bias.

I have written numerous times about how women and women's health is misunderstood, misdiagnosed, ignored or invisible.

Centuries of gender bias in medical research and healthcare have contributed to the harm that women suffer when they seek care and treatment; treatment that they have every reasonable expectation will improve their health and wellbeing.

While harm in our health system occurs across the board to women and men, women are far more likely than men to be the victims of medical injury and patient harm. For example, Dr Kelly Burrowes, a senior researcher at the Auckland Bioengineering Institute, University of Auckland, wrote that "eight out of ten of the drugs removed from the US market between 1997 and 2000 were withdrawn because of side effects that occurred mainly or exclusively in women. Between 2004 and 2013, US women suffered more than 2 million drug-related adverse events, compared with 1.3 million for men."[2]

This was in large part owing to the fact that sex differences in the way that drugs work in women, and the adverse effects they might cause, are simply not adequately studied, or historically, studied at all. It wasn't until 1997 that the US Food and Drug Administration that licences medicines in the US, "published a rule requiring manufacturers to show evidence of how their drug is safe and affected by age, sex and race."[2]



Essure — just one of the articles on medical injury suffered by women that has featured in the Auckland Women's Health Council Newsletter.[3]

Professor of Social Medicine, Dr Jill Fisher of the University of North Carolina's centre for bioethics, says that what is being taught in medical schools about how long-term gender bias is affecting outcomes for women, is a decade behind what is being uncovered in medical research. As a result of the delay in that knowledge becoming embedded in medical practice, in almost every field of medicine there are harms that are being inflicted on women.[4]

The OECD says part of the issue with poor outcomes for women is their limited inclusion in healthcare decision-making and research.[5] It follows that if women are under-represented in systems that licence medicines and devices, or in systems that oversee safety of medicines, devices and processes within healthcare, then the visibility of women — their perspective and needs, and their safety — is far more likely to be ignored, fobbed off or overlooked.

Women have higher unmet healthcare needs, and this is substantially contributed to by an elevated risk of mis- and under-diagnosis among women compared to men. Women are more likely to receive

* Primidos was an oral hormone based pregnancy test, used in the 1960s and 1970s. It was withdrawn from sale in 1978 because of the serious harm caused to babies, including physical and intellectual disabilities and defects, and death through miscarriage, still birth and deformities that were inconsistent with life.

† Sodium valproate is one of several anti-seizure medications taken for epilepsy and bipolar disorder, and also for migraine prophylaxis and pain management. Anti-seizure medications can cause physical and neurodevelopmental effects in children if taken by mothers during pregnancy.

an improper diagnosis, particularly being wrongly diagnosed with mental health conditions when they present with physical diseases and conditions.[5]

Drs Drossman and Ruddy found that some doctors believe that "emotional rather than physical causes lead to women's pain, even in the presence of clinical tests which show their physical nature". They "may incorrectly diagnose women with chronic pain as having a mental health condition without proper evidence and are more likely [to] prescribe psychotropic drugs."[6]

A Spanish study, published in 2024, investigated the gendered outcomes of low-value practices in primary care; that is, treatment that did not meet recommendations according to the Choosing Wisely campaign methodology to mitigate overuse. The study found that female patients were prescribed a significantly higher volume of low-value practices than males with the same health issue (45.7% for women versus 36.5% for men), and were more likely to suffer a preventable adverse event — an injury resulting from medical management or a complication (21.3% of female patients compared with 15.8% of male patients).[7]

We live in a world in which gender bias in health-care is still a significant problem resulting in significant harm; a world in which women are under-represented in research, in decision-making, and in the agencies responsible for licencing therapeutic products and overseeing post-marketing surveillance. There is a disproportionate impact on women from medical injury harm in health care and it is hard not to come to the conclusion that those with the power to change this, simply don't care enough.

There is a joke that has been around for decades, that if men had to have their penis or testicles examined in a machine akin to a mammography machine, squashed between two rigid plates, they would have come up with a much better system. It's funny because we all know it's true!

The reality is that if men suffered the sort of preventable harm in the health system that women suffer — the pain, morbidity, loss of quality of life, sometimes even death — and at the rate that women suffer this harm, far more would be done about addressing it.

Our current Government has been presented with a direct request for, and clear arguments in favour of, the establishment of an independent Patient Safety Commissioner. There is strong medical and economic evidence that New Zealanders — patients and the health workforce alike — would derive considerable benefit from a proactive, responsive

and nimble agency to combat and reduce preventable, avoidable harm to patients, that would work independently yet hand-in-hand with our existing health entities. That the Health Select Committee has failed to make any recommendations at all, let alone one to establish a patient safety commissioner, shows no courage and no foresight.

It seems that they simply don't care enough.

References

1. Cumberlege J, 2020: *First Do No Harm: The Report of the Independent Medicines and Medical Devices Safety Review*. 8 July 2020, London. Crown Copyright.
2. Burrowes K, 2021: Gender bias in medicine and medical research is still putting women's health at risk, *The Conversation*, 8 March 2021.
3. Claridge S, 2023: A Legacy of Pain and Disability: What Essure has Inflicted on New Zealand Women, *Auckland Women's Health Council Newsletter*, November 2023; pp 3-11.
4. Neville S, 2024: How medical research is failing women, *Financial Times*, 2 August 2024.
5. OECD, 2025: *Gender Equality in a Changing World: Taking Stock and Moving Forward*, Gender Equality at Work, OECD Publishing, Paris.
6. Drossman D and Ruddy J, 2020: Improving Patient-Provider Relationships to Improve Health Care, *Clin Gastroenterol Hepatol*. 2020 Jun;18(7):1417-1426.
7. Mira JJ *et al.*, 2024: Gender Disparities in Adverse Events Resulting From Low-Value Practices in Family Practice in Spain: A Retrospective Cohort Study, *Int J Public Health*. 2024 Jul 16;69:1607030.