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ASSOCIATION OF SALARIED MEDICAL SPECIALISTS

DESPATCHES FROM THE FRONT LINE:

SENIOR DOCTORS TALK ABOUT SPECIALIST WORKFORCE SHORTAGES IN NEW ZEALAND'S PUBLIC HOSPITALS

CONTENTS

FOREWORD

DR HEIN STANDER | ASMS NATIONAL PRESIDENT

The shortages of medical specialists in New Zealand have been well recognised by Government. In October 2010, then Health Minister Tony Ryall acknowledged publicly: "We have a workforce crisis in New Zealand because we need to retain more of our hospital specialists". More recently, in 2015, Health Workforce New Zealand (HWNZ) acknowledged: "The most important [health workforce] issue is the impact of a prolonged period of medical labour market shortages on the workloads, wellbeing and productivity of DHB-employed senior doctors."

Many New Zealanders will not be aware of these shortages because, on the face of it, our health system appears to be coping well. Each year more operations are performed, there are more first specialist assessments, more hospital discharges, and patient satisfaction surveys are usually highly positive. But it is not so much a matter of what we are doing so much as what we are not able to do where the shortages bite. There are two key aspects to this.

First is the extent of New Zealand's unmet health need, which is evident in a number of ways. We know both anecdotally and through figures made public about such things as the thresholds for hip and knee surgery that an increasing number of people are just not getting the health care they need. The recent revelation that thousands of patients are not receiving the ophthalmology follow up appointments that they require (leading to loss of their sight) is yet another sad example of the pressure the system is under and ongoing shortages of specialists to perform the work.

A World Bank report, using data from the Lancet Commission on Global Surgery, ranks New Zealand 24th out of 35 OECD countries on the number of surgical procedures performed per 100,000 people.[1]

International studies have shown New Zealanders' access to specialist services is poor when measured against comparable countries, with relatively long waits for both an initial referral to a specialist and for treatment once a diagnosis has been made.[2 3]

In one significant health area, New Zealanders' survival rates after being diagnosed with cancer are significantly worse than Australians'. There are a number of factors relating to this. One is about having timely access to hospital specialists to reduce delays in cancer diagnosis. A New Zealand study (in preparation) shows that in comparison to Victoria and New South Wales, general practitioners' access to tests and referrals to specialists in New Zealand were more limited and wait times for testing were longer; average times for a colonoscopy to be done and reported were 20 weeks in New Zealand, compared to 5-6 weeks in Australia.[4 5 6]

The second major consequence of specialist shortages is that hospital services are less effective and efficient than they could be. This affects the quality and safety of care as well as creating financial waste.

There is a strong body of evidence showing that when specialists are able to spend more quality time with patients and families, more time for training and supervision of other medical staff, and for clinical leadership and developing strong clinical teamwork, patient outcomes improve and savings are made through more efficient, integrated practice and reduction in medical errors.

Instead, many specialists work in conditions that do not allow them adequate time with patients or any other of the activities mentioned above. They are also struggling to find time for continuing medical education and professional development, which are critical in keeping up to date with rapidly changing technology and advances in treatments.

At the same time, New Zealand's growing and aging population is adding further stress on the health care system. While the specialist workforce has also grown, it has not kept up with the increasing workload pressures and increasing demand. The upshot is specialists finding they are in a continuing holding operation. This is well illustrated in two major ASMS studies. The first, published in November 2015, found many district health board-employed senior medical officers (SMOs) routinely go to work when they are ill.[7] The main reasons for doing so include SMOs not wanting to let their patients down and not wanting to over-burden colleagues. The second study, assessing the extent of fatigue and burnout in the SMO workforce, published in August 2016, found 50% of respondents reporting symptoms of burnout.[8] The results of this study have now been published in the BMJ Open: **http://bmjopen.bmj.com/content/6/11/e013947.ll?keytype=ref&ijkey=drr5XIHfT3hfuXZ.** A full report of the research is available on the ASMS website at **http://www.asms.org.nz/wp-content/uploads/2016/08/Tired-worn-out-and-uncertain-burnout-report_166328.pdf.**

In another significant piece of ASMS research, we found that a quarter of DHB-employed members intend to leave either medicine or their district health board employers in the next five years. Of those who intend to stay, 40% might look at reducing the hours they work, 30% would like to decrease their on-call and/or shift work, and 8% would like to stop doing on-call altogether. Coupled with the findings on presenteeism and burnout among SMOs, these results add to the picture of a senior medical workforce increasingly under pressure and struggling to cope.

There are more reports and evidence coming forward that we are returning to the age of managerialism. Doctors are being told by DHB management to perform more first specialist assessments (FSAs) in order to meet MOH targets in order to avoid financial penalties. This has reached the stage where doctors can no longer see patients for follow up appointments in a timely manner and fulfil the duty of care that they have to review patients already in their care. This not only risks the health of patients but also potentially the career of the doctor if found in breach of good patient care. This significantly adds to the pressure and stress doctors are working under.

Looking into the future we know we will have to spend more time with patients as advance care planning becomes more and more important, especially with an aging population. Furthermore, New Zealand is in the process on launching the "Choose Wisely" campaign which will have benefits for patients and it will also make the health system more cost effective. However, helping a patient to make the right choice requires spending more time with a patient and discussing the logic of not doing certain test or investigations.

If the public's perception is that the New Zealand health system is on the whole coping well, it is because the health service staff – not least the medical specialists – have so far managed to hold it together, despite the pressures, but often at the cost of their own health and wellbeing.

The Association of Salaried Medical Specialists (ASMS) has produced this series of articles to put a human face to what the medical literature and the statistics are telling us, and show how the shortages affect the lives of both patients and specialists alike.

Dr Hein Stander
ASMS National President

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PSYCHIATRY SHORTAGE ADDS TO PRESSURE ON THE SPECIALIST WORKFORCE

DR MARTIN O'SULLIVAN

A national shortage of psychiatrists is making its presence felt in Northland.

Child and adolescent psychiatrist Martin O'Sullivan, who works at Whangarei Hospital, says it's an ongoing struggle to recruit and retain psychiatrists in the area. While the psychiatry service is usually short by one or two FTE, at the moment it's down by several people – and that puts pressure on existing staff.

"There's no question that services here are stretched," says Dr O'Sullivan. "In a community like Northland there are high levels of adversity, poverty, alcohol and drug use, and there is a sense of a widening gap between the haves and the have-nots. It's a stressful environment for psychiatrists to work in."

The Northland shortage is part of a bigger national and international picture. Overall, New Zealand is below average among OECD countries in terms of specialists (including registrars) per population, with 1.6 specialists per 10,000 population in 2014 compared with the OECD average of 1.7.

A glance at the New Zealand medical registrar shows that, as at July 2016, there were 566 vocationally registered psychiatrists with New Zealand addresses. That works out at 1.2 psychiatrists per 10,000 people, based on current population estimates.

The state of the mental health and addictions workforce has been on the mind of health decision-makers for a while, and various reports have been published.

Earlier this year ASMS made a submission to the Ministry of Health on its draft Mental Health and Addiction Workforce Action Plan 2016–2020. A full copy of the ASMS submission is available at: **http://www.asms.org.nz/wp-content/uploads/2016/03/Submission-to-MOH-Draft-Mental-Health-and-Addiciton-workforce-action-plan_165097.3.pdf**

The Ministry's action plan acknowledged shortages in the specialist workforce and anticipated a doubling of demand for mental health and addiction services by 2020. Despite this, ASMS noted in its submission that the actions outlined to address workforce issues were tentative and largely dependent on the availability of funding.

Not good enough, said ASMS. Given the pressures on the workforce, improving the situation needed to be a 'must do' rather than an optional extra.

"A coherent approach to increase the attractiveness of specialist mental health roles in the workforce is critical, including a strong commitment to recruitment and retention measures based on developing attractive environments and conditions in which to practise," reads the ASMS submission.

The strains of workforce shortages and inadequate resourcing are becoming more apparent, with two significant pieces of research by the ASMS finding high rates of both presenteeism **(http://www.asms.org.nz/presenteeism/) and burnout (http://www.asms.org.nz/wp-content/uploads/2016/08/Tired-worn-out-and-uncertain-burnout-report_166328.pdf)** among New Zealand's senior doctors and dentists.

These surveys show – overwhelmingly – that many doctors are working through illness and that burnout is prevalent and a cause for great concern. Some medical specialties reported higher levels of burnout than others – in particular, emergency medicine, dentistry and psychiatry.

The fact psychiatry features prominently doesn't surprise Martin O'Sullivan, who says working in the speciality now is more stressful than ever. He attributes this to various factors. On a personal level, he estimates a local child psychiatry case-load burden that is up to four times the New Zealand norm.

"When you factor in the number of children and adolescents in this large rural district, the small FTE of child and adolescent psychiatrist clinical time (1.2), our exemplar access rates and the extent of adversity which our community experiences it is a considerable burden," he says.

"For my adult psychiatry colleagues there has been higher than usual occupancy rates in the DHB's psychiatric inpatient unit in recent years, resulting in patients who are very unwell by the time they enter the hospital system."

On-call work is more onerous, and psychiatrists in the region do a high proportion of first on call. All of this has led to some historic tensions with management over hearing and acting upon clinical concerns. Some of those factors, such as the relationship with management, are definitely improving but others continue to be a concern.

"Colleagues tell me that there's a very high threshold for admission to Whangarei Hospital's adult inpatient unit," says Dr O'Sullivan. "When patients are admitted, they are often very ill with high levels of aggression or high risk of suicide. It's very challenging to provide treatment in these circumstances and to know that people are not fully recovered by the time they leave the hospital."

Martin O'Sullivan moved to New Zealand four years ago from a role as Clinical Director at the Mater Hospital in north Dublin and a stint as a consultant with the South London and Maudsley NHS at Guy's Hospital in south London. He came here for a year but fell in love with the place. His experience gave him a realistic understanding of resourcing difficulties, but he thinks Northland's issues need to be addressed.

Recruiting and retaining psychiatrists has been an ongoing battle, he says.

"There is a small pool of potential applicants and if people know there are problems with resourcing here it can be hard to attract people to the area. The fact we don't have a clinical director is an additional problem for the service. The reality for local clinicians is that they have so much on, they can't contemplate taking on additional leadership responsibilities."

The answer, at least in Northland, requires an effective clinical and managerial partnership that provides opportunities for real collaboration and shared decision-making. The service also needs a clinical director and the inpatient unit needs to expand its bed numbers to ease some of the pressure on psychiatrists.

"It's a very resilient community here. That's one of the first things that struck me. Ultimately, though, it's our families or whanau who take on the burden of receiving people who are still quite unwell back into the community. While it's stressful for psychiatrists we shouldn't forget our families who bear the brunt of these resourcing issues."

THE CHALLENGE OF PROVIDING PSYCHIATRIC CARE IN OLD AGE

New Zealand's psychogeriatricians are struggling to keep up with the demand for treatment as the population lives longer.

This aging population includes more and more people living with conditions that require psychiatric diagnosis, treatment and care. Some people have lived with these conditions for most of their lives, while others have acquired them in old age.

"We know that by 2031, more than 22.2% of the population will be older than 65 and in 2051 that will have risen to a quarter of the population," says Dr Jane Casey, a consultant psychogeriatrician at Auckland District Health Board, and the current chair of the Faculty of Psychiatry of Old Age within the Royal Australian and New Zealand College of Psychiatrists (RANZCP).

"We have an aging population that is generally healthy and well, but there will be a subset who have significant depression, anxiety or psychotic illness and age-related cognitive decline."

She says more psychogeriatricians will be needed if the public hospital specialist workforce is to meet both the current level of demand in addition to what lies ahead.

The numbers tell some of the story. The standard thinking has been a formula of one psychogeriatrician to every 10,000 people in the population, but New Zealand currently averages one psychogeriatrician per 17,000 people. There are regional variations (see sidebar for a breakdown by DHB).

However, just to complicate matters, it's not a straight numbers game. Jane Casey makes the point that some psychogeriatricians are working in large rural areas, while others are providing treatment in areas with a very diverse population and complex needs, or a higher than usual concentration of people aged 65 plus, or of people in aged residential care.

AT A GLANCE

Jane Casey provided the following snapshot of the psychogeriatric medical workforce and the issues they're facing in some DHBs.

NORTHLAND:
2 FTE for 28,000 people. Currently advertising – short of consultants, beds and community services.

COUNTIES MANUKAU:
5.5 FTE for 50,000 people. Filling a shortfall with overseas-trained doctors and recruiting two locums from overseas.

WAITEMATA:
8.3 SMOs and 1 medical officer for 75,000 people. Well-resourced on the surface but the region is short of allied staff (eg, psychologists). Another SMO would take pressure off the service.

AUCKLAND:
6.8 SMOs and 1 medical officer for 50,000 people. Although well-staffed for the population, the service is struggling to cope with demand and manage waiting lists. The region includes a high number in residential care.

WAIKATO:
5 SMOs for 60,000 people.
The workforce is very stretched.

LAKES:
1.6 SMOs for 15,000 people. But as with Waikato, the service covers a large rural area so is very stretched. Both SMOs are overseas-trained and one has provisional registration.

BAY OF PLENTY:
2.2 SMOs and 1 medical officer for 40,000 people. A locum is providing maternity cover.

TARANAKI:
1.8 for 18,000 people. No medical officer and just one house officer.

MIDCENTRAL:
A population of 27,000. 1 FTE and could do with another.

WAIRARAPA:
0.2 FTE for 8,000 people, in private capacity.

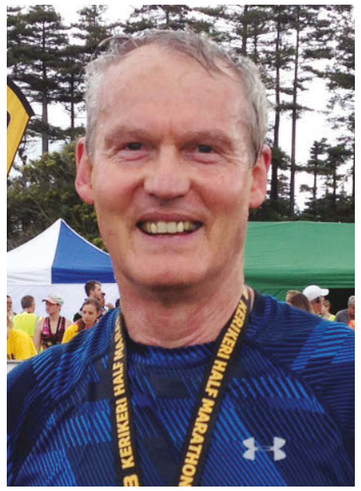
HUTT VALLEY:
1.7 FTE for 18,000.

CAPITAL & COAST:
2.7 FTE for 35,000 people.
The service needs at least 3 FTE.

CANTERBURY:
8.9 for 73,000 people. Includes 2.1 medical officers and 1.7 are not members of the Faculty of Psychiatry of Old Age (FPOA).

SOUTH CANTERBURY:
0.5 FTE for 13,000 people.

SOUTHERN:
2.1 FTE for 47,000 people in Otago but no SMO in Southland, which is of concern.



DR GAVIN PILKINGTON

DR JANE CASEY

The numbers tell us that the workforce of psychogeriatricians is already playing 'catch up', but it's a complex picture.

Dr Gavin Pilkington, a psychogeriatrician at Waitemata DHB, says psychogeriatrics became a sub-specialty in the 1990s and involves two additional years of advanced training on top of the three years of specialist psychiatry training.

He says his career in psychogeriatrics has had four distinct phases.

> *"The early years were fantastic because it was a new specialty, and we were welcomed with open arms. Then it became busier and we stopped doing some of what we would consider essential work, such as acting as a consultant liaison to geriatric medicine wards.*

"In the third phase, the service became very stretched and difficult to manage. We're in the fourth phase now, where we're trying to recover from that. We're doing quite well at Waitemata but it varies a lot around the country – and even though we're doing well here by comparison, we still struggle to get our job-sized non-clinical time."

He says Waitemata gets 1,000 new psychogeriatric referrals each year, resulting in about 150 hospital admissions.

"We're dealing with people developing mood disorders and sometimes becoming severely unwell, people who are suicidal. It's the level of risk that triggers their hospital admission. Some people have a diminished capacity for self-care – for example, if they have dementia. Some people pose a risk to themselves or to others, while another group of people have very complex health conditions and suddenly become unwell.

Gavin Pilkington says one of the difficulties for the workforce is the long lag between the time it takes to understand an issue, such as the aging of the population, and the time it takes to bring about changes in health services in order to meet the changing demand.

"We're in the position of being reactive, rather than proactive."

Jane Casey has 21 years' experience as a public hospital specialist in psychogeriatrics, and she loves her job.

> *"Old age psychiatry is seen as the least glamorous sub-specialty but for those of us who are passionate about the field and about old people, it's the most rewarding and diverse area to work in," she says. "We see it as a very privileged role to be in, being with older people who share their lives and wisdom with us."*

Even though her DHB – Auckland – has the numbers it needs on paper, she says the specialists there are still not coping with the demand coming in the hospital doors. She believes a better way of gauging workforce requirements would be to look at the wider picture in terms of the geography, the needs of the population, workforce skill-sets and the services required.

"There are some good things happening with the service in New Zealand but they are happening in isolation and it's very piecemeal. Overall, we are still significantly behind parts of the UK and Australia when it comes to psychogeriatric services."

ABOVE: DR DARION ROWAN
BELOW: DR AMANDA OAKLEY

THE PUBLIC DERMATOLOGY CRISIS THAT'S MORE THAN SKIN DEEP

THE NEED FOR DERMATOLOGY DIAGNOSIS AND TREATMENT IN THE PUBLIC HEALTH SYSTEM IS SET TO DOUBLE IN COMING YEARS BUT THE SERVICE WILL NOT BE ABLE TO COPE IF IT CONTINUES IN ITS CURRENT STATE, WARN DERMATOLOGISTS AMANDA OAKLEY AND DARION ROWAN.

They say the public system is desperately short of dermatologists and unless something significant is done to address this, more and more New Zealanders will find themselves unable to access the specialised medical care they need.

The two doctors are already seeing the evidence of widespread unmet need in their waiting rooms and clinics.

"We turn away about a third of people," says Darion Rowan, who has worked as a dermatologist at Auckland's Middlemore Hospital for more than 30 years.

> *"Some of them don't need to be seen by us, but we are also turning away people who should be seen. People are languishing out in the community with terrible skin conditions. It's very unsatisfactory, and you feel for the patients."*

That's echoed by Waikato District Health Board dermatologist Amanda Oakley.

"Just look in my waiting room. The people who are there often have terrible diseases. We don't see anything minor in the public hospitals."

The pair say there is a real shortage of training positions for emerging dermatology specialists, a serious shortage of funded public positions for trained specialists, and a lack of dermatologists to apply for the positions that are available. At the same time, the dermatology workload has been growing in recent years as a result of New Zealand's aging population, and the greater prevalence of skin cancers and obesity-related illnesses.

They believe the current situation is unsustainable, and their concerns are supported by a report on the state of the dermatology workforce published by Health Workforce New Zealand on the Ministry of Health website. The Dermatology Workforce Service Forecast was prepared by a group of dermatologists, led by Darion Rowan, and can be found at http://www.health.govt.nz/our-work/health-workforce/workforce-service-forecasts/dermatology-workforce-service-forecast.

The report identifies a number of problems, including:

- a lack of dermatology specialist positions in public hospitals
- limited access to publicly-funded dermatology services, varying greatly across DHBs and regions
- regional variations in the range of dermatology treatments offered
- a need for stronger dermatology training in New Zealand along with more dermatology education for GPs as services are increasingly provided outside of hospital settings

- difficulties accessing data on dermatology in New Zealand as this is not routinely recorded or centrally collected
- New Zealand lagging behind other countries in the development of standards, guidelines and pathways for dermatology.

Darion Rowan says the report's authors have recommended:

- every DHB to have a dermatologist-led team, requiring an increase to 30 dermatologists working in the public sector (up from the current figure of 16 FTE)
- comprehensive dermatology training provided, with public consultant posts available at the end of training
- dermatology services to be equitably accessible across New Zealand, with all DHBs to run a full dermatology service with improved access to paediatric dermatology
- a Centre for Dermatology Expertise to be established
- Increased public awareness of the role dermatologists play, particularly in the management of skin cancer
- better information gathering and data collection relating to the dermatology workforce and the conditions they are treating.

She says dermatologists are now looking to Health Workforce New Zealand and the country's 20 DHBs to ensure a good plan is in place to provide a sustainable public dermatology service now and in the future.

> *"The service must expand to address the current deficit, long waiting lists and predicted increase in demand, as well as providing equity of access to dermatologic services across the country."*

Dermatologists are trained to investigate, diagnose and treat a wide range of illnesses, including skin cancers, up to 30 common skin conditions such as eczema and psoriasis, and about 3000 rare skin diseases.

To become a dermatologist, medical school graduates work for three years in a public hospital. They then sit a physician training exam with the Royal Australasian College of Physicians before becoming eligible to enter advanced training in dermatology. That involves another four years of concentrated study, research and practice at a variety of approved training centres in New Zealand and overseas.

> *Dermatology has been recognised as a medical specialty in New Zealand for nearly 70 years. Back in 1948, it cost two guineas to join the new Dermatology Society in New Zealand, and eight people signed up. These days the Society has about 60 members, many of them in private practice, and there has been considerable sub-specialisation within the field.*

All DHBs provide some form of dermatology service, but few dermatologists work in public hospitals. Instead, the service is provided mostly by visiting specialists, locums or through private contracts.

GPs are often the first point of contact for a dermatology-related consultation, although Amanda Oakley and Darion Rowan say there is a limit to what they can do.

"For example, dermatologists are the best at diagnosing melanoma," says Amanda Oakley. "Other specialties remove many benign lesions unnecessarily in case they might be melanoma. That's a safe practice, but it is expensive and may be unnecessary, and there may be surgical complications."

Concerned by the high levels of unmet need she was seeing, Amanda Oakley banded together with several other dermatologists earlier this year to start up a telemedicine dermatology practice to contract to DHBs, GP organisations and other New Zealand health care providers that require clinical advice from a dermatologist. For example, they provide a diagnosis where this is uncertain, assist with triaging prior to a referral to a face-to-face service, and offer advice on investigations or the management of conditions.

"Some doctors cannot access a hospital appointment for their patients unless they require inpatient care, but most people don't actually require this," she says.

Darion Rowan says dermatology services in the private sector help to reduce the pressure on the public health system, but the reality is that these can be accessed only by people who are insured or able to pay for the service.

She is strongly of the view that the Ministry of Health should not expect GPs and other doctors, who are already over-worked, to bridge the gaps in dermatology services without the support and expertise of qualified dermatologists.

> *"It is not good practice and could put patients at risk due to incorrect diagnosis and treatment."*

And another problem looms on the horizon: the workforce forecast report says that 32.1% of dermatologists surveyed in 2009 had indicated they were planning to reduce their hours, retire or move overseas, compared with 20.8% who were thinking of increasing their hours.

"We have a number of dermatologists who really want to retire but they can't," says Amanda Oakley.

"There are others among us that can't see any succession planning. I don't plan to retire any time soon but I look at the calendar and my birthdays, and I can see that at some time it will have to happen."

GYNAE-ONCOLOGY

SHORTAGE OF GYNAECOLOGICAL ONCOLOGISTS LEAVES SERVICE VULNERABLE

Knocking off work for the day means different things for different people – time to catch up with family or friends, to go for a run, read a book (or write one), plan a trip, or tackle the mountain of laundry that's grown in our absence. The boundary between work and personal time is not always clear-cut, of course, but for many of us there comes a point in the day when we are able to shake off the tethers.

For Cecile Bergzoll, however, the work day often just blurs into the work evening. When the sun goes down and the clocks tick over and the buildings begin to cool, she rolls up her sleeves to do all of the things she couldn't get to earlier: correcting letters, analysing data for business cases, contributing to annual reports, polishing presentations.

And on some of her days off, she operates on patients.

"There is so much to do," she says.

Dr Bergzoll is a gynaecological oncologist based in Wellington, and one of a handful scattered around New Zealand. For a country of this size it has been estimated we need at least 11 gynaecological oncologists distributed across Auckland, Wellington and Christchurch. Instead, we have just 7 of them, and they're struggling to cope.

Dr Bryony Simcock, Gynaecological Oncologist, Canterbury:

"Gynaecological oncology in New Zealand provides a world class service in less than world class conditions. We need to be staffed appropriately.

> *"It's not exactly rocket science. If any one person fell, then the system would topple. It's that vulnerable."*

Associate Professor Peter Sykes, Canterbury:

"It takes a while to train a sub-specialist, and there's an international market."

About a thousand New Zealand women a year are diagnosed with a gynaecological cancer, most commonly uterine cancer (about 40%), followed by ovarian cancer (34%), cervical cancer (18%) or vulval/vaginal cancer (7%).
Up to 70% of women with gynaecological cancer require radical surgery and/or specific radiation therapy procedures.

Historically the treatment of these cancers fell to general gynaecologists but in recent decades a new sub-specialty has emerged to bridge the medical words of oncology and gynaecology – known as gynaecological oncology, and nested within its parent specialty of obstetrics and gynaecology.

The sub-specialty first appeared in the United States and Australia during the 1960s/70s, and by the 1980s both countries had solid training programmes in place. It was slower to take root in New Zealand – affected at least partly, says Peter Sykes, by the fallout from the 'Unfortunate Experiment' at National Women's Hospital in Auckland, which was exposed by Sandra Coney and Phillida Bunkle in 1987. Significant public mistrust made obstetrics and gynaecology (and its fledgling offshoot) a less attractive option for many doctors.

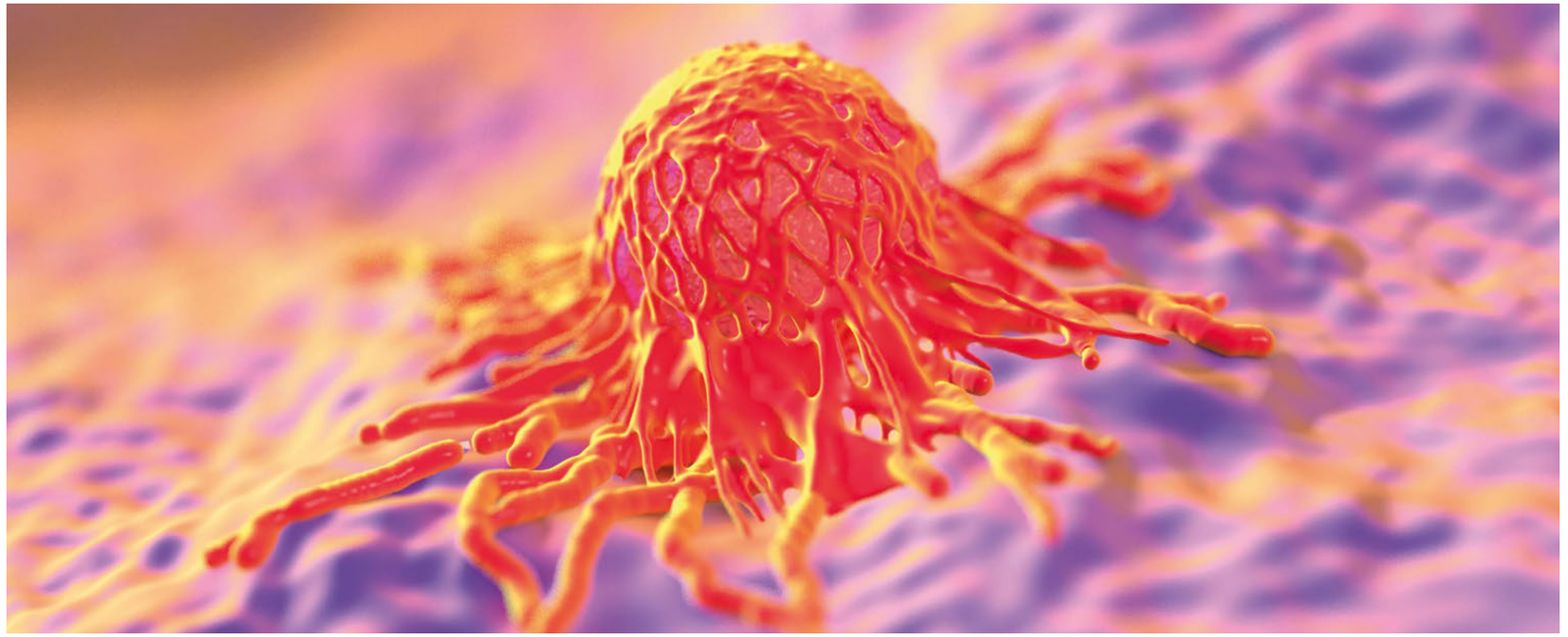
By the 1990s, however, the new sub-specialty had begun to make its presence felt, and in 1997 Peter Sykes returned to New Zealand after a period of sub-specialty training overseas. He was this country's first certified gynaecological oncologist.

But while the number of sub-specialists has grown in stops and starts since then, securing funding for training and positions, and then recruiting to them, has been very difficult.

"There's been no funding for training in this country," says Peter Sykes.

DR CECILE BERGZOLL

ASSOCIATE PROFESSOR PETER SYKES



ASMS CONCERNED BY INADEQUATE RESOURCING

"The ASMS is very concerned by the inadequate resourcing of gynaecological oncology in this country," says ASMS Executive Director Ian Powell.

"We're talking about very small teams of dedicated and highly skilled professionals who are dealing with very heavy workloads and doing everything they can to ensure that women in their regions receive the best possible treatment for gynaecological cancer.

> *"Burnout is a real concern for this group and such heavy workloads are not sustainable. It's not sensible to have a situation where the service is made vulnerable by the absence of any one specialist."*

"This service needs to be properly funded and resourced to ensure it is sustainable. If it collapses due to inadequate resourcing, that would be a disaster for the medical specialists and other dedicated health professionals who have spent years training and working in this area, and also for the many women who stand to benefit from their expert treatment and care.

> *"The shortage in this area is part of a bigger picture of entrenched shortages in the medical workforce which needs to be addressed."*

> *"All the O&G has been focused on obstetrics roster cover so gynaecology oncology has been a Cinderella, less of an immediate need than other things."*

In addition, the lure of Australia and other countries has been strong. Three years of sub-specialty training is provided in Australia – and many of the registrars who have gone to Australia to train have subsequently decided to stay there.

That's hardly surprising, says Peter Sykes. The Australian gynae-oncology centres are bigger,

more developed and better supported. The workload is less onerous because there are more specialists, and people are able to earn more.

> *"It's not just about the money. It's about the mix of things. Here you might be working on your own, having to set up a service.*
>
> *"It's tough yakker doing that. I did it for the South Island at one point. I was in the hospital seven days a week, and I did that for a decade. People are working very hard to make sure the service works."*

New Zealand sub-specialists have also struggled to get proper recognition of the need for their service from district health boards (DHBs), he says.

In 2010 the Ministry of Health asked a group of doctors, nurses, managers, patient representatives to audit gynaecological cancer care services in New Zealand. Their report, 'It Takes a Team', was submitted in July 2011 to the New Zealand Gynaecological Cancer Group (NZGCG) and is available online at http://www.health.govt.nz/publication/it-takes-team. The group proposed a national service plan for gynaecological oncology to improve equity and access to treatment. The preferred model of care involved a multi-disciplinary team, led by two or three gynaecological oncologists, in four expert centres spread around New Zealand.

Peter Sykes says the Ministry has indicated approval for three centres of expertise – Auckland, Wellington and Christchurch – but these do not come with central funding attached. It is now up to DHBs to provide adequate resources, hence the business cases that the Wellington team, led by Cecile Bergzoll, has been working at night to prepare.

"My workload involves three full-time days of administration, which I don't have time for, so I do it in the evenings," she says.

It has been estimated that Wellington requires three gynaecological oncologists for the 240 women diagnosed with gynaecological cancer each year in the central region, which covers seven DHBs from Wellington to Hawke's Bay and Taranaki. Instead, the region has just Cecile Bergzoll as 1FTE and Howard Clentworth who works part-time and is due to retire within 18 months.

"We are short on the ground. We are not able to deliver the care we would like at all levels, and working in isolation as a specialist is not good," says Dr Bergzoll.

"The team in Wellington has been struggling for years with limited theatre time, nursing time and literally no administrative support. Every member of the team is working very hard to give the best care they can, given the circumstances."

All three specialists agree that Wellington is hardest hit by the shortage.

"If Cecile left Wellington, there would be a major problem," says Peter Sykes. "It's very fragile. There could be major problems with service provision. She desperately needs help."

Capital & Coast DHB has approved temporary funding to appoint a locum gynaecological oncologist for 12 months. It's not a proper fix but, given the circumstances, this will buy some time until a permanent solution is secured.

Bryony Simcock says the workload pressures are being felt all around the country, and she cites the example of a Fellow who pulled out after one year of her fellowship because of the size of the workload.

"At the international gynaecology cancer meeting, which is held every two years around the world, one of the speeches was on the rate of burnout among gynaecological oncologists, especially among women who are trying to do so many things," she says.

"You're working, working, working. You wouldn't do it if you didn't have a complete passion for it. You're dealing with women whose quality of life is threatened or their lives are at risk. We love it, absolutely, but it's very demanding."

Peter Sykes says DHB chief executives have signed off on the model of three centres of gynaecological oncology expertise.

"It's just middle management getting all wrapped up in the business cases and the money. If the DHBs really recognise the need for this, they will fund it. They have to."

He is optimistic the situation will improve over the next five years, given the Ministry's support for a three-centre model. The others are less sure, but remain hopeful.

Cecile Bergzoll:

> *"If we can make this work in the central region, it will be great. It will be a real system improvement that could help women. We're not asking for the moon. If I could just get a colleague and a secretary and a dedicated nurse in Wellington, then patients could get adequate treatment faster and consistently."*

APPEARED IN THE SPECIALIST ISSUE 102 – MARCH 2015

IMPROVING THE NATIONAL GYNAE-ONCOLOGY SERVICES

The report 'It Takes a Team' prepared for the Ministry of Health and submitted in 2011 outlines a proposed national improvement plan for gynaecological cancer services. The full report can be read at: http://www.health.govt.nz/system/files/documents/publications/it_takes_a_team-_national_plan_for_gynaecological_cancer_services_22_july_2011.pdf

The report's findings include:

- All women with gynaecological cancer should have timely and equal access to appropriate multidisciplinary specialist cancer services, but this was not the case in New Zealand.
- Gynaecological cancers comprise about 10% of all cancer cases and 10% of all cancer deaths in New Zealand.
- Evidence shows that women generally have better outcomes if they are treated by a sub-specialist trained gynae-oncologist and reviewed by a multidisciplinary team.
- A review had found that, on average, women with ovarian cancer treated by a gynae-oncologist as part of a multidisciplinary team lived an additional 11 months.
- The New Zealand Cancer Registry shows that Maori and Pacific women have a significantly higher incidence rate of endometrial and cervical cancers than non-Maori and non-Pacific women. Maori women also have poorer survival rates for cervical and endometrial cancers.
- Gynae-oncology in New Zealand is a small, vulnerable but essential service for women and their families. The report identified the following challenges with service provision:
  - building a sustainable workforce
  - achieving equitable access to evidence based services
  - aligning the funding and purchasing framework with optimal provision
  - collecting data on quality and outcomes.
- There was a strong rationale for improving national coordination and planning of services. However, no one at that time had the mandate or capacity to agree on the best way to develop and use New Zealand's gynaecological cancer resources. There was no clear decision mechanism to ration access to gynae-oncologists.
- The lack of national coherence also meant there was no standard set of referral pathways and no nationally agreed clinical guidelines.

DR JOANNA GLENGARRY

STAFFING SHORTAGES PUSH FORENSIC PATHOLOGY SERVICE TO THE BRINK

The national forensic pathology service would struggle to cope if another earthquake as lethal as the Christchurch shakes occurred today, says the clinical leader of the service.

Clinical Director Simon Stables says the country's small team of forensic pathologists is so stretched already that shouldering the extra workload associated with a natural disaster is almost unthinkable.

"We don't have the numbers," he says.

Fellow forensic pathologist Paul Morrow agrees.

"One of the things we always have hanging over our heads is the potential for something like a plane or bus crash, or an earthquake," he says. "Frankly, it could be a real embarrassment for the Government if a disaster should happen because they would find out very quickly that the resources are not available in New Zealand to deal with it.

"We're managing at the moment, but our ability to do so is razor thin."

Another forensic pathologist, Joanna Glengarry, says the national service is very vulnerable.

"All it would take is for someone to get sick while someone else is away, and we'd have just one forensic pathologist covering the whole upper half of New Zealand. The shortage we're dealing with could quickly become catastrophic."

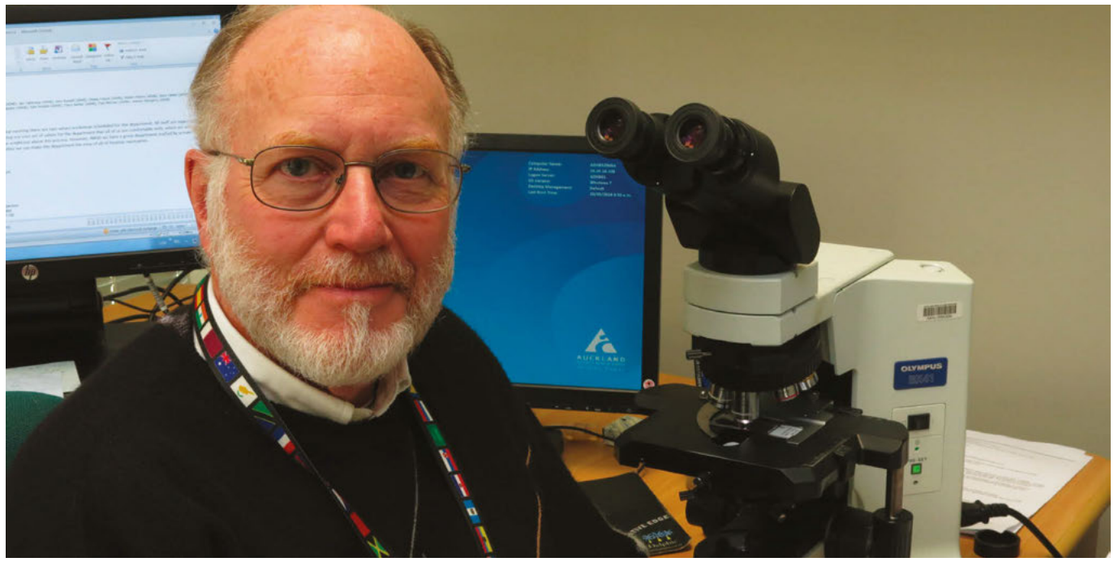
Forensic pathology hit the headlines earlier this year when media reported that the national service was on the brink of a "catastrophic unravelling", with the prospect that some autopsies might not get done and inquests would be put off (**http://www.radionz.co.nz/news/national/300667/crisis-time-for-forensic-pathology,-doctor-warns**). That might sound dramatic but forensic pathologists say it's an accurate assessment of the situation. There simply aren't enough of them to do the work with enough stretch within the team to handle anything unexpected that arises.

Drs Simon Stables, Paul Morrow and Joanna Glengarry are based at LabPlus at Auckland Hospital, and provide forensic pathology for the upper half of the North Island. The remaining forensic pathologists are based in Palmerston North, Wellington and Christchurch. Together, the six of them form the National Forensic Pathology Service administered by Auckland DHB under contract to the Ministry of Justice. That contract is currently being renegotiated.

The national service came into existence in 2005 after years of negotiations, replacing an ad hoc system that Simon Stables says lacked structure, resourcing, governance, adequate succession planning, career advancement or ongoing training programmes. It provides a round-the-clock service to police, coroners and the public, and carries out about 1600 post mortems each year. According to Auckland DHB, between 170 and 190 post mortems are associated with homicides or suspicious deaths.

The service used to provide post mortem support to Samoa, Rarotonga and Tonga, but Simon Stables says it is not in a position to do so now unless it has more forensic pathologists. In the meantime, those countries are turning to Australia for assistance.

Like other specialties, to become a forensic pathologist involves years of additional training following medical graduation and experience as a house surgeon. There are a couple of pathways into the specialty. Some doctors choose



DR PAUL MORROW

to do a forensic fellowship involving five years of study with the Royal College of Pathologists Australasia, while others opt to train first as an anatomic pathologist before completing a Diploma in Forensic Pathology, which means an extra six years of study at a minimum.

Those years of specialty training are still very fresh in the mind of Joanna Glengarry, who, at 37, is one of the service's two most recently qualified specialists. Initially she wanted to be a surgeon but was drawn instead to anatomic and then forensic pathology.

"It was clear to me in my third year during my mortuary rotation that forensic pathology was the career for me," she says. "It was that brilliant mix of surgery and pathology, as well as the medico legal side and the opportunities to interact with the coroners and courts. It was just so fascinating, and a great intellectual challenge."

She completed the Diploma in Forensic Pathology in Melbourne two years ago, and has been back working in New Zealand since the start of 2015.

So, is she enjoying it?

She hesitates. The work is so varied, she says. It's interesting and rewarding, and the medical side of things is wonderful. She has great colleagues, and there's no other job she would rather be doing.

"Unfortunately, however, that comes with a big 'but', which is to do with the frustrations of workforce resourcing.

"I'm exhausted. I've accrued 77 days of leave and I'm trying to work out how I can take it. The only way I can reliably take leave is to attend a work conference and then tack on a week's leave afterwards. So far this year I've worked out that I've been on call nearly every second week. My phone is always on in case I need to go into work. It would be great to just spend the weekend in the garden and know that I'm not going to be called in."

In a small specialised team like forensic pathology, doing work that is critical to families and to the justice system, being short by even one person can mean the difference between staying on top of the workload and scrambling to keep up. Simon Stables says the national service really needs at least three more forensic pathologists if the pressure on existing staff is to ease to more manageable levels.

And there are consequences of the shortage: delays for families, hold-ups with processing cases moving through the justice system, the personal toll of too much work and constantly being on-call for the doctors themselves.

"I got an email this morning about a family that can't get access to an insurance payout because there's no cause of death yet," says Simon Stables. "They have my sympathies and I'm trying to get that case prioritised. In situations like this, families can be living day-to-day while they're awaiting the release of funds, or they need the body of their loved one for a tangi. It can be very difficult."

At the same time, says Paul Morrow, forensic pathologists have to proceed with caution and thought because if they get it wrong, the consequences can be severe.

"The more stressed you are, the more likely you are to make a mistake. A homicide could end up being missed, a finding could be misinterpreted that could result in someone either being charged with a crime or not being charged."

It can take up to 100 hours to complete all of the work required for a single case in the justice system.

"People think that once you've done the post mortem, you have the answer, but the post mortem is just the beginning," says Simon Stables.

"Forensic pathology is like any other branch of medicine. We take a history – what the person has been doing in the lead up to their death, their social context, any symptoms and so on. We examine the person and get extra tests done as needed, and then we integrate all of that information. With living people, doctors come up with a diagnosis. In our case, we determine the cause of death."

Joanna Glengarry says the amount of time involved is poorly understood. The Auckland team, for instance, covers the area from Taupo to Northland. If the police ask a forensic pathologist to attend a scene of death, that person may need to travel a long way.

"It might just be one case in the justice system but it might have involved an eight-hour round trip for one of us, and then we have to perform the autopsy, prepare for court, many hours of consultation and review, and then there's the court testimony itself," she says.

APPEARED IN THE SPECIALIST ISSUE 107 – JULY 2016

DR SIMON STABLES

"Even when a case is closed by a coroner, it's still an ongoing case for us as we need to continue liaising with families and the courts, etc."

And the stress of being on call so often shouldn't be under-estimated, says Paul Morrow.

Originally from Vermont in the United States, he moved to New Zealand in 2009 after a long career as a medical examiner and chief medical examiner. He says the national forensic service here was in better shape back then, with a fully staffed office and a one-in-four call. The new Coroners Act had come into being a few years earlier, and coroners and forensic pathologists were in the process of redefining their roles.

"Since then I'm struggling to think of a time when we haven't been short of staff."

He decided to retire last year when he turned 66, and says he felt guilty about leaving his colleagues. He's now back working half-time, but says he has been very careful to protect himself from some of the big stresses of the work – in particular, the requirement to be on call.

"It's an inherent part of medical work but it's a big cause of stress," he says. "It's driven me from every job I've had because even if you're not actually working all of the time, you can't go to a movie without having your beeper on and knowing that you might have to sneak out. It really begins to wear on you and can burn you out. I'm too old for that now so I have ensured that I am no longer on call."

Addressing the forensic pathology shortage requires far-sighted decision-making, adequate resourcing, and effective recruitment and retention. Without sufficient trainees the service has relied upon overseas trained forensic pathologists to maintain the service, which has left little opportunity for service development and succession planning. Recruiting from overseas has become extremely difficult as other countries, such as the United States, now recognise the importance of keeping their own forensic pathologists and are doing so by enhancing local working conditions and salaries.

There is no doubt that the demand and capacity for forensic pathologists will only increase as the population, and thus the workload, increases. Coupled with this is the diminishing desire and availability of laboratory pathologists to become involved with coronial autopsy work, which means that forensic pathologists are expected to undertake additional and responsive work for the Coroner, which is difficult to do when they are struggling to maintain their own service.

At least one part of the picture, the three forensic pathologists believe, involves getting medical students excited about the possibilities of pathology.

"Everyone knows what surgeons or anaesthetists do," says Joanna Glengarry. "Pathology, not so much. It's more removed from clinical practice on the wards, and forensic pathology is even more removed because the only time other doctors interact with us is when their patients die.

"At the moment I'm teaching first year house surgeons how to certify death. Everything in their medical training is focused on the new and fantastic ways to keep people alive, which is great, but it means that death is now seen as a failure so there's a lot of mystery around the process of death and why it occurs. Autopsies, though, are just like any other medical procedure. It's still surgery – the only difference is that my patients are deceased."

As forensic pathologists await the results of the contract negotiations between Auckland DHB and the Ministry of Justice, they are focusing on staying on top of the work, trying to recruit into the workforce, and hoping that an earthquake or other disaster does not strike until there are more of them to deal with it.

Discussions are also underway to secure a solution to these issues and develop a long-term strategy.

But for one of the forensic pathologists, the gloss is wearing off.

"I'm supposed to be the ridiculously enthusiastic young person in the department, but that's not how it is," says Joanna Glengarry.

She was bonded to return to New Zealand following her Diploma training in Melbourne but is struggling to see why she should stay here when that bonding period ends early next year.

"It feels extraordinarily disloyal to be thinking about going back to Australia. I have the utmost respect and fondness for my colleagues, so the idea of leaving is very very hard and is not a decision I'll make lightly – but there's just so much more I could achieve in a place that is better resourced."

ADVANCE CARE PLANNING FOR A PALLIATIVE MEDICINE WORKFORCE CRISIS

When someone is sick, a clear expression of what is important for them if they were to get sicker or die can help to ensure their future wellbeing, and provide the most appropriate treatment and care.

Such planning for the future is critical if we are to ensure people get the care that best relieves suffering, and supports them and their families.

AS WITH PEOPLE, SO WITH SERVICES

Palliative medicine itself is sick, with a rapidly worsening workforce crisis.

Immediate action and careful planning for the future are needed if we are going to provide equitable high quality specialist services to New Zealand's rapidly aging population.

CURRENT SITUATION

There are 55 palliative medicine specialist positions in New Zealand, spread between community palliative care services (hospices) and hospital support teams. Of these posts, 22% are vacant. Within the next five years, a further 42% of the current workforce will retire[1].

> *Palliative medicine itself is sick, with a rapidly worsening workforce crisis.*

As a result, 30 new specialists are needed within five years to maintain services at existing levels.

At current training rates we may train between 5-10 new specialists during this time. An additional one third of new specialist posts are also required to address current inequities, ensure services' sustainability, and meet future need.

FACTORS EXACERBATING THE CRISIS

Firstly, services need to expand to address current unmet need in people with non-malignant conditions. Palliative care need is as high in these people as it is in those with cancer – most services mainly care for the latter, resulting in inequitable access.

Secondly, population projections show a rapid and large increase in the elderly population living longer with chronic illness over the next decade, with almost certain implications for increase in service provision for palliative care services.

> *Services need to expand to address current unmet need.*

Thirdly, many services are not sustainable with their current workloads and levels of specialist cover. About 40% of district health boards (DHBs) either have no specialist cover, or only partial cover (hospital or hospice, but not both), and single practitioner services are not sustainable long-term, given the workload.

> *Many services are not sustainable with their current workloads and levels of specialist cover.*

Finally, recruiting from overseas is difficult – there is a shortage of specialists in many countries. Competition is fierce and in fact in the past five years, New Zealand has lost five trainees to Australia – in a period when we have only trained 10.

To ensure there are enough specialists to meet future population need and ensure services are sustainable and viable, it is estimated that the current number of positions needs to expand by 34% within the next 5-10 years. This would take the workforce to a total of 74 posts.

ADDRESSING THE CRISIS

To address the issue, we either need to train more specialists, attract more to New Zealand, or develop other aspects of the workforce.

In palliative care, the third approach is already underway with development of nurse practitioners and specialist roles, as well as allied health and counselling expertise. Even with expansion of these posts and new ways of working, these non-medical positions are unlikely to significantly reduce the number of specialists needed down the track. Rather, they will help enhance the breadth of service provision to a wider proportion of the population, thus helping to reduce inequalities.

Increasing registrar training positions is the most viable option in the short to medium term, given how difficult it is to recruit from overseas. There are currently nine fullyfunded three-year training rotations in the country. This means that both the Health Workforce New Zealand (HWNZ) and the DHB funding have contributed to funding the rotation. If, however, we only continue to train at the current rate, the number of specialists in five years will be fewer than at present.

Maximum training capacity, were funding available, is currently 14 posts countrywide, an increase of 5 from what we have now. This could be increased even further to 19, were it not for the current workforce crisis limiting the numbers of specialists available in the regions to be supervisors.

HWNZ has clearly identified palliative medicine as a vulnerable specialty in crisis. As a result it has released enhanced funding for up to 11 posts, and is currently considering increasing to 14. Although this is encouraging, and HWNZ has written to the DHBs encouraging them to fund new rotations, as yet there has been little expansion with DHBs saying they have other priorities.

One solution would be to centrally recognise the workforce crisis, and pump prime for a six-year period the urgently needed DHB component of the rotations at a national, coordinated, strategic level through the Ministry of Health. Such targeted ring-fenced money for areas of priority has precedent and would seem to be the most effective way of rapidly and effectively driving the increase in posts needed. For example, a recent National pre-election pledge of $20 million dollars has targeted community palliative care services (hospices and aged residential care).

Either this or an alternative solution requiring creative leadership and funding from the Ministry is urgently needed.

CONCLUSION

Action is needed to comprehensively and effectively implement a plan for the future wellbeing of palliative medicine training and the specialist workforce. Failure to do so will mean that in five years from now, specialist palliative care services for many parts of the country will almost certainly be diminished and unable to provide appropriate medical care.

> *Urgent action is needed.*

This will happen at a time when palliative care services will be needed more than ever.

DR ANNE O'CALLAGHAN, CHAIR OF THE PALLIATIVE MEDICINE TRAINING AND COORDINATION COMMITTEE (PAMTRACC), AND CLINICAL DIRECTOR, AUCKLAND HOSPITAL PALLIATIVE CARE SERVICE.

DR JONATHAN ADLER, MEMBER OF THE PALLIATIVE MEDICINE TRAINING AND COORDINATION COMMITTEE (PAMTRACC), AND CLINICAL LEADER, WELLINGTON REGIONAL HOSPITAL PALLIATIVE CARE SERVICE.

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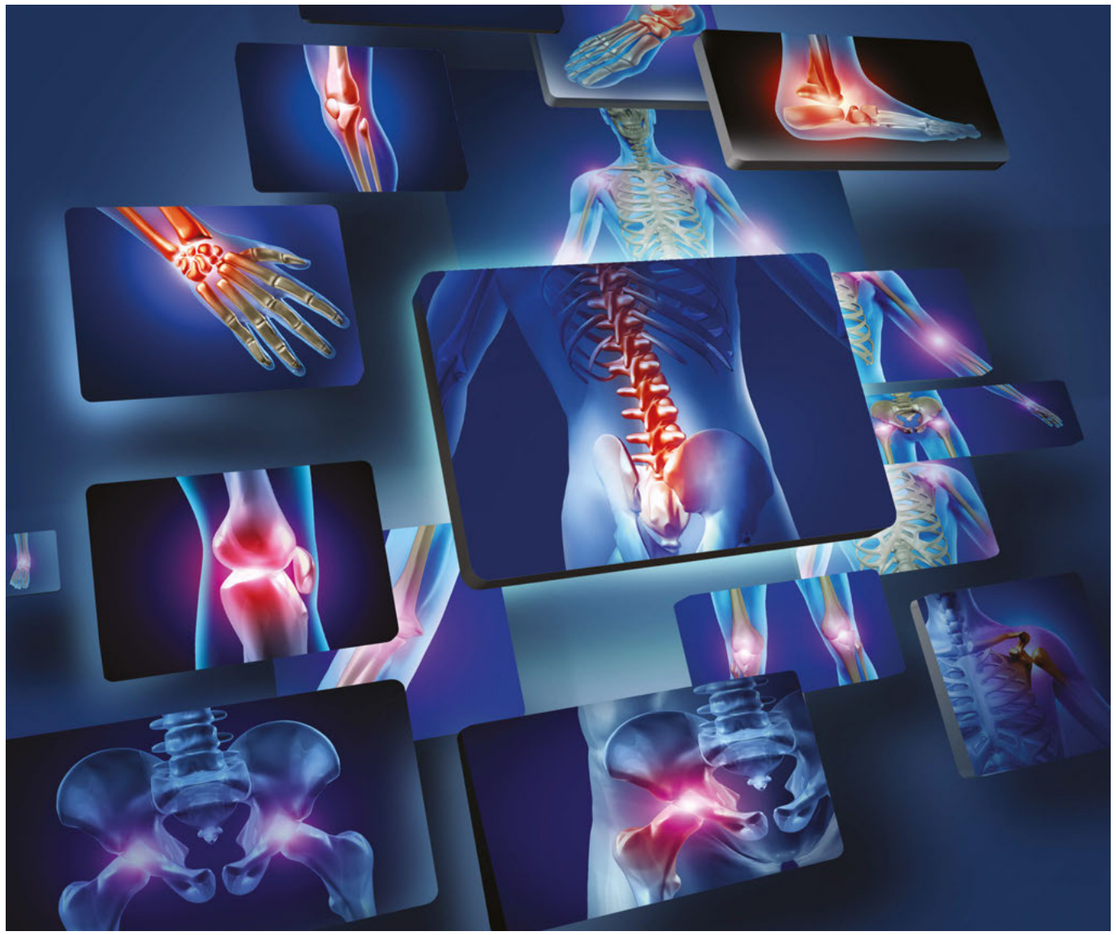


RHEUMATOLOGY WORKFORCE SHORTAGE

The frustration is evident in rheumatologist Fiona McQueen's voice as she recounts how, a couple of weeks earlier, she saw a 30-year-old man with long-standing back pain and discovered he had a severe rheumatic disease that could be treated.

But that's good news, right?

"He'd been suffering with this condition since his late teens," she says. "A treatment has been available for a number of years and he really should have been seen by a rheumatologist at least three years ago."

Hence her frustration, borne out of long-standing shortages in the public hospital rheumatology workforce.

"Getting money out of the DHBs is like getting blood out of a stone, but this is having an impact on patients," she says. "There's a lot of people we can't get to see, which leaves them reliant on their GP, who may be very good but obviously isn't a specialist in this area. It's a real concern for rheumatologists."

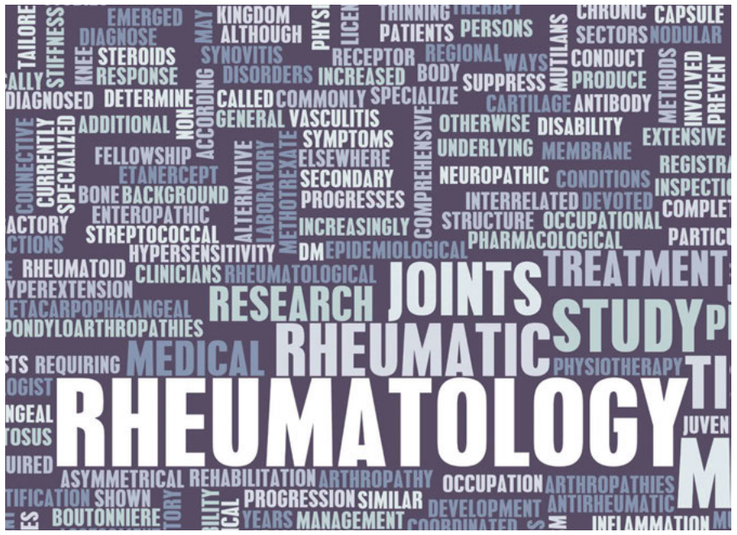
Dr McQueen moved to Invercargill last year to take up a part-time (0.4 FTE) position with the Southern DHB, after spending most of her working life as a rheumatologist in Auckland. She also works part-time (0.1 FTE) as a Professor of Rheumatology at Auckland University, and is President of the New Zealand Rheumatology Association.

She's been at the sharp end of rheumatology service provision and training for more than 20 years, and says improvements are needed to provide the level of rheumatology treatment New Zealanders require.

"We need more publicly funded rheumatology positions, probably another 5 to 8 FTE, and we need to incentivise

APPEARED IN THE SPECIALIST ISSUE 106 – MARCH 2016

DR FIONA MCQUEEN



jobs in the regions where they're desperately needed."

Estimates of how many rheumatologists are needed vary across countries, but have been conservatively benchmarked at one rheumatologist for every 100,000 people. The most up-to-date figures available show wide variations across New Zealand, with shortages in two places in particular standing out: in 2012, Northland had just 0.64 FTE per 155,800 people (one full-time rheumatologist to 243,438 people), while Nelson-Marlborough had 0.5 FTE per 136,800 population (one rheumatologist to 273,600 people) over the same period.

And even in regions that appear to be doing well by comparison, the situation is less than rosy, according to Fiona McQueen. For example, patients covered by the Southern DHB face a unique set of hurdles in getting to see a rheumatologist; they need to travel great distances, and in this region there is very limited private rheumatology provision.

Rheumatologists diagnose and treat a range of conditions such as arthritis, autoimmune connective tissue disease, systemic inflammatory diseases such as vasculitis, spinal and soft tissue disorders, certain metabolic bone disorders, and chronic musculoskeletal pain syndromes. After graduating from medical school it takes at least seven years to train as a rheumatologist (longer if additional PhD or other study is involved), with advanced rheumatology training undertaken through the Royal Australasian College of Physicians (RACP). By the time the finish line is in sight, many of the new specialists have families and are feeling very settled in their current locations.

"Trainees don't necessarily want to move or to work in the provinces," says Fiona McQueen. "Positions there can be seen as dead-end jobs – which they're not – and people can be very reluctant to move out of the bigger centres. There might be less support from other specialties in small areas, which can be a real issue. It means that jobs in Auckland are being snapped up, but it can be harder to recruit in other places. We need to incentivise those positions."

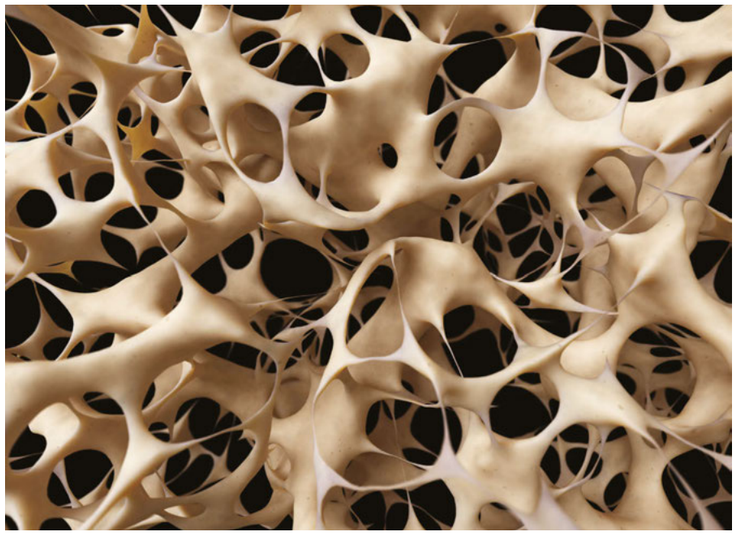
There's also the lure of Australia – Fiona McQueen says rheumatologists crossing the Tasman are able to earn significantly more money and have more access to resources and support.

Issues with the rheumatology workforce and service provision have been well documented. Hutt Valley DHB rheumatologist Andrew Harrison analysed the provision of rheumatology services in New Zealand over a decade ago and subsequently reported his findings in the *New Zealand Medical Journal* (23 April 2004). He concluded that access to rheumatologists varied markedly, depending where patients lived, and that the shortage of rheumatologists appeared to be worsening. Waiting lists were often used as surrogate indicators of the adequacy of service provision, he wrote, possibly because they were easier to measure than true unmet need.

> *"Waiting lists, however, do not take account of the unmet need of patients who, due to lack of access to rheumatology services, are referred to a less appropriate specialty or managed in general practice."*

More recently, a review of the musculoskeletal workforce and service published by the Ministry of Health in March 2011 **(http://www.health.govt.nz/system/files/documents/pages/musculoskeletal-workforce-service-review.pdf)**, while not specifically about rheumatology, highlights a number of broader issues that affect rheumatologists. These include the growing number of people with conditions such as arthritis, the need to better integrate GP training within orthopaedic and rheumatology clinics, and existing barriers to improved provision of care, which include the DHB funding model and inconsistent use of clinical team members across hospitals.

The report argues for more consistency in managing patient referrals, and that's a message that's been picked up in rheumatology by Waikato DHB rheumatologist Douglas White and a team of other clinicians. They have developed a triaging tool that involves a short set of three questions to be answered by the



DR DOUGLAS WHITE

referring GP and a further three questions for the triaging rheumatologists. It's early days but they think that using the tool electronically can reduce the turnaround on referrals from five days to one day.

Their research has been published in the international *Journal of Clinical Rheumatology* (August 2015) and also won an award for excellence in health improvement at last year's APAC Forum in Auckland (**https://www.100Ominds.com/about/news/health-improvement-award**).

"This project is about streamlining the process," says Douglas White.

"As a country we have fewer rheumatologists per head of population than many other countries. We can't provide the same service that rheumatologists do in other countries so we have to be selective about the patients we see. The shortage of rheumatologists is driving the need for work-arounds."

RHEUMATOLOGY SPECIALIST WORKFORCE AS AT 2012*

DHB	2012 FTE	FTE PER POPULATION
NORTHLAND	0.64	243,438
AUCKLAND	3.16	139,589
WAITEMATA	2.4	220,208
COUNTIES MANUKAU	3.26	147,761
WAIKATO, BAY OF PLENTY, LAKES, TAIRAWHITI, TARANAKI	5.55	148,468
HAWKE'S BAY	1.4	109,929
MIDCENTRAL	1.3	127,692
WHANGANUI	0.6	105,333
WAIRARAPA, CAPITAL & COAST, HUTT VALLEY	2.5	188,280
NELSON-MARLBOROUGH	0.5	273,600
CANTERBURY, WEST COAST	2.625	203,657
SOUTH CANTERBURY	0.4	139,000
OTAGO, SOUTHLAND	2.3	130,609

Source: Andrew Harrison, from a presentation at the 2012 New Zealand Rheumatology Association Annual Scientific Meeting.

* Service provision may have changed since these figures were compiled.

SHORTAGE OF PAEDIATRIC SURGEONS

NEW ZEALAND FACES AN ONGOING STRUGGLE TO TRAIN AND RETAIN ENOUGH PAEDIATRIC SURGEONS TO KEEP UP WITH THE LEVEL OF NEED, SAY ASMS MEMBERS SPENCER BEASLEY AND BRENDON BOWKETT.

They're two of this country's small pool of paediatric surgeons, and they say more of these specialists are urgently needed.

"We're currently down about 20% on the number we need," says Spencer Beasley, a paediatric surgeon at Christchurch Hospital and also Clinical Professor of Paediatrics and Surgery at the University of Otago.

"Each of the four centres – Auckland, Hamilton, Wellington, Christchurch – has been advertising for someone or is about to advertise."

He says there's a worldwide shortage of paediatric surgeons, most markedly in developing countries, but also in countries such as New Zealand.

That's echoed by Brendon Bowkett, a paediatric surgeon at Capital & Coast District Health Board, who says New Zealand has 12 or 13 paediatric surgeons but needs more – at least four surgeons in each centre but ideally slightly more than that.

> *"Many paediatric surgeons, including myself, would like to be involved in preventative and rehabilitative work," he says.*

"Paediatric surgeons in many countries are deeply involved in that kind of work. It's an essential area as that's where many

LEFT: SPENCER BEASLEY; RIGHT: BRENDON BOWKETT

of the recent advances in improving child mortality and morbidity have occurred.

"With the current numbers, the opportunities to do that are pretty much non-existent."

He says many children are treated in an adult environment in New Zealand, and surgeons need more time to lobby and support governance structures to facilitate appropriate standards of care for children.

"The 20 DHB model has focused a lot of resources on structures which are removed from child health and patient care. For example, despite the clinical risk, it appears to take several years for jobs to be advertised and filled."

SHARED TRAINING PROGRAMME

New Zealand and Australia share a training programme, with trainees selected on merit by a single body. There's no quota of trainees from each country – and Spencer Beasley says that's an issue for New Zealand.

"New Zealand trainees have to do some of their training in Australia and because they tend to be very good, they then get offered jobs in Australia," he says. "It's a very attractive option for them because the centres are bigger and better resourced, they will be doing less on-call work and they have the ability to earn more."

Spencer Beasley and the country's other paediatric surgeons are doing their best to convince trainees and new graduates that the opportunities they're seeking are available on this side of the Tasman, too. It's a tough job: so far just three of the last nine New Zealand trainees who have gone through the Australasian programme have returned to New Zealand to work, with most opting to stay in Australia.

Brendon Bowkett says that in the past year, seven people have been taken onto the advanced paediatric surgery training scheme but six people have left or been removed from the programme.

"So we have a net gain of just one person."

Paediatric surgeons, like other specialists, are also grappling with issues of workload, fatigue and stress, he says.

"Work stress is such that I am now aware of three paediatric surgeons who have fallen asleep or crashed their cars because of tiredness when on intolerable rosters."

Spencer Beasley says it has proven hard to recruit and also difficult to get locums for the roles.

"There are about three or four New Zealanders in training at the moment but they're at different stages of their training so they're not immediately available."

ATTRACTING PAEDIATRIC SURGEONS TO NEW ZEALAND

Part of the challenge for Spencer Beasley and Brendon Bowkett and their colleagues is to get across the message to trainees and new graduates that New Zealand also has some very strong attractions.

"There are only four paediatric surgical units in New Zealand so we all know each other and work very well together," says Spencer Beasley. "There are also opportunities to do a broader range of surgery here, whereas in a bigger centre in Australia, the opportunities may be narrower. And of course there are the benefits of living in New Zealand, too. That's very attractive to many people, to return here to live and work."

He sees two possible solutions to the current situation – either introducing a quota for New Zealand trainees that matches our anticipated needs, so that an appropriate number can be accepted onto the A ustralasian programme, or to allow New Zealand trainees to do all of their training in New Zealand.

He says a review of tertiary services in 1998 looked at paediatric surgery but there is a real need for Health Workforce New Zealand to carry out a separate review of the specialty to see what is needed now and in the future.

"What happens at the moment is that the four surgical units get the complex and rare conditions, but probably the greatest contribution they can make is for simple things like hernias, which require good clinical judgement and expertise.

> *"When I go to Greymouth once a month, the patients there receive the same quality of care that they get in Christchurch or Melbourne. We travel a lot to provide care for families close to their homes, but overall we're struggling to provide adequate support to some other DHBs. We need to entice people back to work here."*

Brendon Bowkett is not convinced that providing all of the training in New Zealand will solve the problems with recruitment and retention, as there are still issues to do with public funding of child health, facilities and coordination.

At the end of the day, he says it's simply about providing the best possible service for the children who need it.

"You need to keep up to date in order to provide the best care, and it's difficult to do that with limited numbers of paediatric surgeons."

SPECIALIST SHORTAGES: AT A GLANCE

- New Zealand has the sixth-lowest number of specialists per head of population out of 32 OECD countries. In 2014, we had 1.54 specialists (including trainee specialists) per 1000 population. The OECD average was 2.09/1000.[1]
- For New Zealand to have had the OECD's average number of specialists per head of population (including trainee specialists) in 2014, we would have needed 9,425 specialists and trainees – or a 36% increase on the 6929 recorded by the OECD.[2]
- Around 466 new specialists (public and private) join the New Zealand workforce each year, but we lose 52% of that number through resignations, retirements, and specialists leaving the country.[3]
- The net growth rate of the specialist workforce is insufficient for New Zealand to catch up with other comparable countries such as Australia. And while the growth rate is leading to increases in first specialist assessments and elective surgery volumes it is insufficient to address both the backlog of unmet need and the growing need brought about by demographic changes.[4 5 6]
- The pressures of increasing health service need, on top of long-standing workforce shortages, are taking a toll on many specialists, with national surveys of ASMS members showing high levels of burnout (50% of respondents) and a high incidence of 'presenteeism' (88% of respondents), where specialists turn up for work when they are unwell.[7 8]
- A quarter of all senior doctors and dentists who took part in a national survey by the ASMS intend to leave either medicine or their DHB in the next five years.[9]
- Long-standing specialist shortages have contributed to New Zealand's record of poor access to health care. For example:
  - New Zealand ranks 24th out of 35 OECD countries on the number of surgical procedures performed per 100,000 people. New Zealand's 6270 procedures per 100,000 population compares with Australia's 10,900 and the OECD average of more than 11,000.[10]
  - OECD health data show that in 2013 New Zealand was ranked 23rd out of 32 OECD countries for all hospital inpatient discharges per 100,000 population.[11]
  - In a study measuring access to services in 11 comparable countries, New Zealand is ranked 11th for access to diagnostic tests, 10th for long waits for treatment after diagnosis, 9th for long waits to see a specialist, and 8th for and long waits for elective surgery.[12 13]
  - Long-term poor access to services has led to increasing unmet health need. A study undertaken in January 2016 shows an estimated 174,000 people needing elective surgery were not able to get on the surgical waiting list, and waiting times were getting longer.[14 15]

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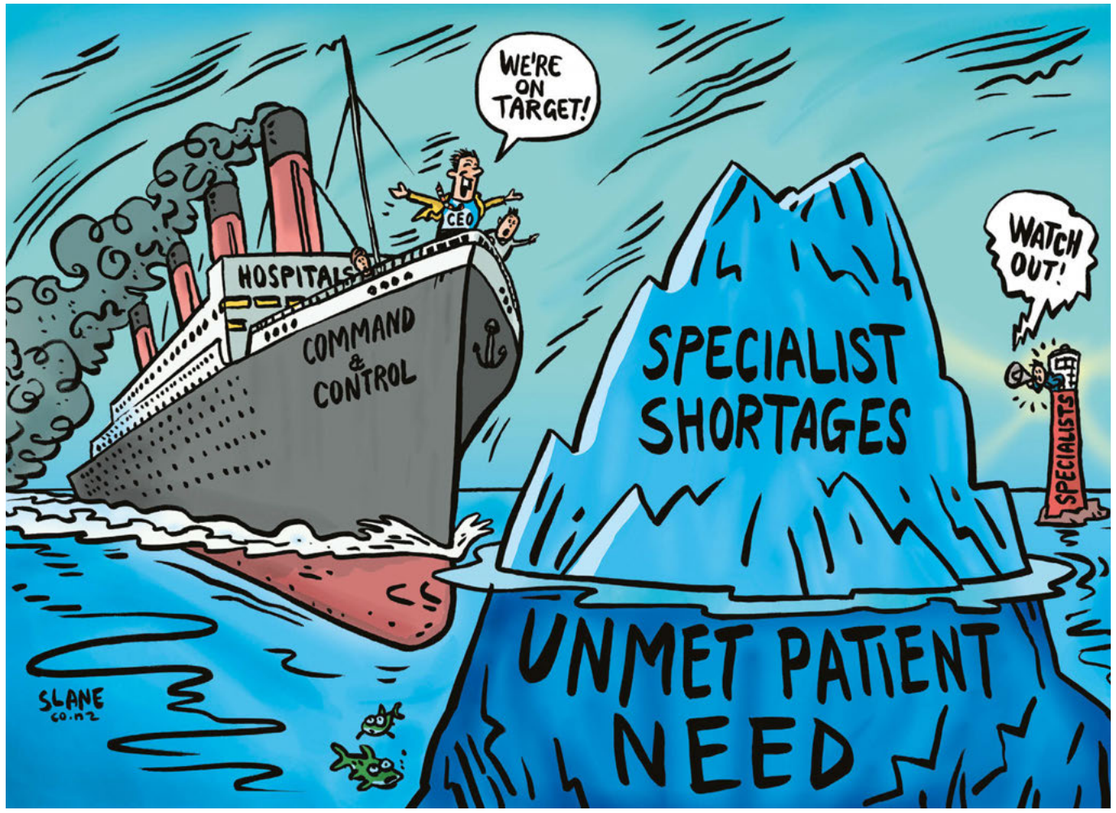

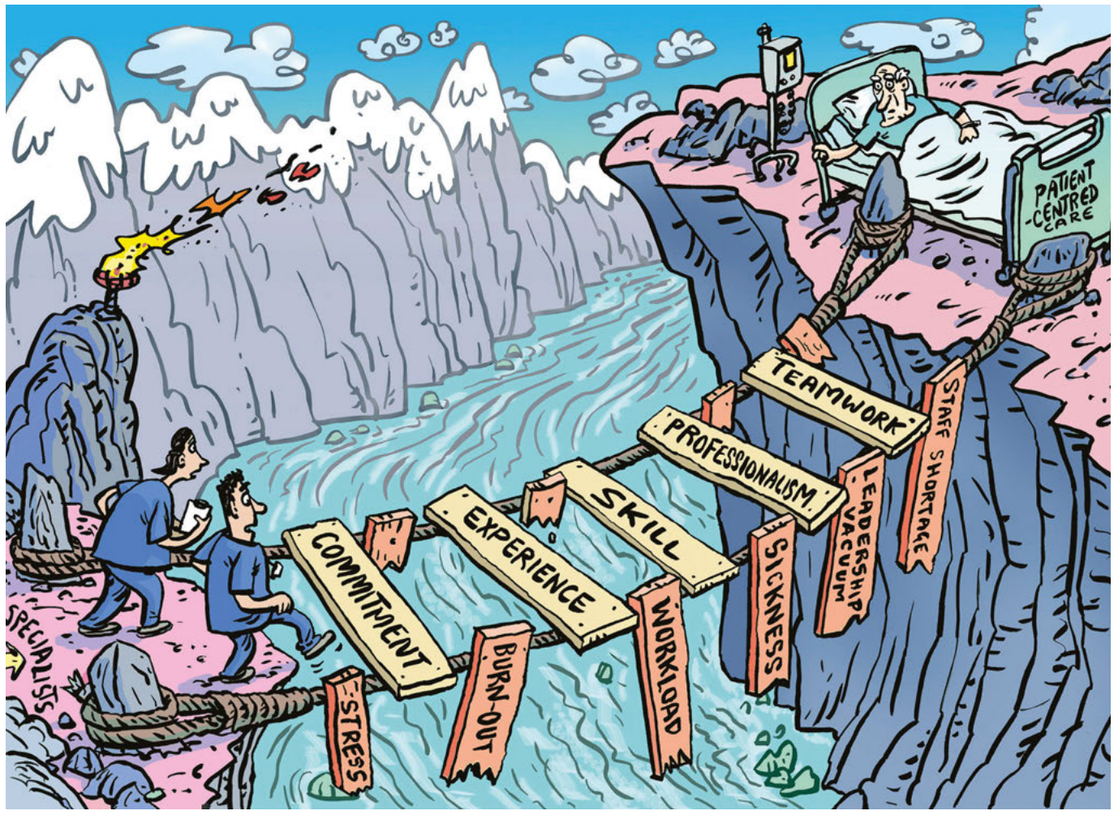

ASMS SERVICES TO MEMBERS

As a professional association, we promote:

- the right of equal access for all New Zealanders to high quality health services
- professional interests of salaried doctors and dentists
- policies sought in legislation and government by salaried doctors and dentists.

As a union of professionals, we:

- provide advice to salaried doctors and dentists who receive a job offer from a New Zealand employer
- negotiate effective and enforceable collective employment agreements with employers. This includes the collective agreement (MECA) covering employment of senior medical and dental staff in DHBs, which ensures minimum terms and conditions for more than 4,000 doctors and dentists, nearly 90% of this workforce
- advise and represent members when necessary
- support workplace empowerment and clinical leadership.

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How to contact the ASMS

Association of Salaried Medical Specialists
Level 11, The Bayleys Building,
36 Brandon St, Wellington

Postal address: PO Box 10763,
The Terrace, Wellington 6143

P 04 499 1271
F 04 499 4500
E asms@asms.nz
W www.asms.nz
www.facebook.com/asms.nz

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ASMS STAFF

Executive Director
Ian Powell

Deputy Executive Director
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Director of Communications
Cushla Managh

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Administration Officer (Communications)
Lydia Schumacher

Director of Policy and Research
Lyndon Keene

Principal Analyst (Policy & Research)
Charlotte Chambers

PO Box 10763, The Terrace
Wellington 6143, New Zealand
+64 4 499 1271 **asms@asms.nz**

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www.asms.nz