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 workday 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 – 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 recruiting to them, has been very difficult. “There’s been no funding for training in this country,” says Peter Sykes.

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 gyna-oncology centres are bigger, more advanced, and have a greater patient load. “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.”

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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.

“The shortage in this area is part of a bigger picture of longstanding shortages in the medical workforce which needs to be addressed.”

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 2010 to the New Zealand Gynaecological Cancer Group (NZGCG) and is available online at http://www.health.govt.nz/publication/it-takes-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 subspecialist-trained gynaecological oncologist and reviewed by a multidisciplinary team.
- A review had found that, on average, women with ovarian cancer treated by a gynaecologist 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 of cervical and endometrial cancers than non-Maori and non-Pacific women. Maori women also have poorer survival rates for cervical and endometrial cancers.
- Gynaecology-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 services based on need
  - 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 gynaecologists.
- The lack of national coherence also meant that there was no standard of referral pathways and no nationally agreed clinical guidelines.