ASSOCIATION OF SALARIED MEDICAL SPECIALISTS

DESPATCHES FROM THE FRONT LINE:

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

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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 vision) is yet another sad example of that they require (leading to loss of patients are not receiving the care they need). The recent revelation that thousands of patients are not receiving the care they need.

Two major ASMS studies. The first, published in November 2015, found many district health board employed senior medical officers (SMOs) routinely do not get to work when they are ill. The main reasons for doing so include SMOs having 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. The results of this study have now been published in the BMJ Open: http://bmjopen.bmj.com/content/6/11/0213947.


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 do more on-call 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 serious medical workforce increasing 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 fulfill the duty of care that they have to revive 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 of launching the “Choose Wisely” campaign which will have benefits for patients and 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 tests 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.
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 FTEs, 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 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 have and 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 specialist psychiatrists (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 addiction workforce has been on the mind of health decision-makers for a while, and various reports have been published.


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 practice,” reads the ASMS submission.


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 specialty now is more stressful than ever. He attributes this to various factors. On a personal level, he estimates a local child psychiatry caseload 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 rate 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 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 looked at from a bigger perspective.

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.
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.

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 dermatology treatments offered across DHBs and regions.

“The need for training positions is actually greater than the need for public positions,” says Dr Rowan.

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

The public dermatology crisis isn’t just about skin deep.
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.

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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 these 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 sustainable to force 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 the 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 care.”

“The shortages in this area is part of a larger picture of unmet need and inadequate resourcing in the medical workforce which needs to be addressed.”

ALL THE O&G HAS BEEN FOCUSED ON ABSTRACTS ROSTER ROSTER ROSTER ROBASTIC ROBASTOR TO GAYNEOLOGY ONCOLOGY.
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, Barotonga 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
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 medical 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 lock 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 work load 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 a 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 Tauranga 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.

“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 Coroner 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 on 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 coronal 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 anesthetists do,” says Joanna Glengarry. “Pathology, not so much. It’s more removed from the clinical practice of 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 students about the possibilities of pathology. Everyone knows what surgeons or anesthetists do,” says Joanna Glengarry. “Pathology, not so much. It’s more removed from the clinical practice of the wards, and forensic pathology is even more removed because the only time other doctors interact with us is when their patients die.”

But for one of the forensic pathologists, the glass 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 wasbonded 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 hard and is not a decision I’m going to 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 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 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.

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 54% 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 inequities.

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 fully funded 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 medicine 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.

REFERENCES
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?”

“I’ve been suffering with this condition since my late teens,” she says. “A treatment has been available for a number of years.”

“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 245,458 people), while Nelson-Marlborough had 0.3 FTE per 126,800 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 that 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 live, and that the shortage of rheumatologists appeared to be worsening.

“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 Wakato DHB rheumatologist Douglas While 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
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.1000minds.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.”

DR DOUGLAS WHITE

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

<table>
<thead>
<tr>
<th>DHB</th>
<th>2012 FTE</th>
<th>FTE PER POPULATION</th>
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<tbody>
<tr>
<td>Northland</td>
<td>0.64</td>
<td>245.408</td>
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<tr>
<td>Auckland</td>
<td>3.16</td>
<td>139.589</td>
</tr>
<tr>
<td>Waitemata</td>
<td>2.4</td>
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<td>Counties Manukau</td>
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<tr>
<td>Waikato, Bay of Plenty, Lakes, Tairawhiti, Taranaki</td>
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<tr>
<td>Hawke’s Bay</td>
<td>1.4</td>
<td>109.929</td>
</tr>
<tr>
<td>Midcentral</td>
<td>1.3</td>
<td>127.692</td>
</tr>
<tr>
<td>Whanganui</td>
<td>0.6</td>
<td>105.533</td>
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<tr>
<td>Wairarapa, Capital &amp; Coast, Hutt Valley</td>
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<tr>
<td>Nelson-Marlborough</td>
<td>0.5</td>
<td>273.600</td>
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<tr>
<td>Canterbury, West Coast</td>
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<td>South Canterbury</td>
<td>0.4</td>
<td>139.000</td>
</tr>
<tr>
<td>Otago, Southland</td>
<td>2.3</td>
<td>130.069</td>
</tr>
</tbody>
</table>

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.
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, and they will be doing less on-call work and 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 PEDIATRIC 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 you would have to do more straightforward things like hernias, which require good clinical judgement and expertise.

"When I go to Greyshorn 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 to come back here to work."  

Brendan 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 in-totable rollers."  

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**NEW ZEALAND PERSPECTIVE**

New Zealand has the sixth-lowest number of specialists per head of population out of 32 OECD countries. In 2014, we had 1,154 specialists (including trainee specialist) per 1,000 population. The OECD average was 2,090/1,000.

For New Zealand to have the OECD’s average number of specialists per head of population (including trainees specialists) in 2014, we would have needed 9,425 specialists and trainees – or a 56% increase on the 6,929 recorded by the OECD.

Around 466 new specialists (public and private) join the New Zealand workforce each year, but we lose 52% of that number through resignations, early retirements, and specialists leaving the country.

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.

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’ (68% of respondents), where specialists turn up for work when they are unwell.  

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.

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 6,270 procedures per 100,000 population compares with Australia’s 10,100 and the OECD average of more than 11,000.
- OECD health data show that in 2015 New Zealand was ranked 23rd out of 32 OECD countries for all hospital inpatient discharges per 100,000 population.
- 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 for treatment after diagnosis, 9th for long waits for treatment after discharge, 9th for long waits for treatment after diagnosis, 9th for long waits for treatment after diagnosis, 9th for long waits for treatment after diagnosis, 9th for long waits for treatment after diagnosis, 9th for long waits for treatment after diagnosis, 9th for long waits for treatment after diagnosis, 9th for long waits for treatment after diagnosis.
- 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.

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**REFERENCES**

1. OECD Health Data, 2016.
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• 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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