Professor Michael Schultz. Photo courtesy Otago Daily Times

SHORTAGE OF GASTROENTEROLOGISTS

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Gastroenterology services are experiencing "unmanageable" increases in demand in bowel cancer and inflammatory bowel disease (IBD) while New Zealand needs 51 more specialists to be on par with Australia per population.

At present it has 1.93/100,000 gastroenterologists compared with 3/100,000 across the Tasman. These are headcount figures; on an FTE basis New Zealand has 1.53/100,000, including private provision.

A recently-released critical analysis of the gastroenterology specialist workforce compiled by the New Zealand Society of Gastroenterology also found four DHBs – West Coast, Whanganui, Tairawhiti, Wairarapa - had no resident gastroenterologists in 2017.

Bowel screening – operating in only eight DHBs after a series of delays – was predicated on faulty assumptions about workforce capacity, the report says. The initial timetable would have seen the programme implemented in all DHBs by the middle of this year. The latest deadline for full implementation is mid-2021.

New bowel cancer cases are increasing by 15% each year in men, and 19% in women.

It is not just bowel cancer treatment and screening piling on additional pressure. New Zealand has one of the fastest growing rates (5.6% per year) of IBD, the collective name for Crohn's disease and ulcerative colitis. The number of patients is expected to double in the next 10 years.

There is an acute shortage of specialist IBD nurses; the ratio at present is 1 to 1155 IBD patients. The report calls for increased recognition of nurses. A fifth of the nearly 21,000 sufferers are children, but New Zealand has no paediatric IBD nurses.

Also, the report says efforts to shift hepatitis C care into the community have been not been successful, while hepatitis C prevalence is rising.

Amongst its recommendations the report calls for the consideration of private sector and Iwi support for establishing scholarships for Māori and Pacific doctors, and for training fellowships in regional centres such as Timaru and Taranaki.

Māori and Pacific people are disproportionately affected, partly because they were more likely to live in DHB areas with no service, and because of general health inequalities.

It also calls for the implementation of the 2018 National Bowel Screening Programme Assurance Review Report, and points to its 2011 workforce report which highlighted the strain on services at that time.

The report calls for a joint Ministry of Health – New Zealand Society of Gastroenterology steering group to oversee the implementation of its recommendations.

Training provision is "suboptimal", and as many as four of the eight new gastroenterologists each year head overseas.

ENDOSCOPY PRESSURES

The report says gastroenterologists on average perform 264 colonoscopies per year in the public system, while general surgeons perform 151 colonoscopies. The initial modelling underlying the national bowel screening programme was based on projections of gastroenterologists performing an average of 660 colonoscopies per year.

"In our view this undoubtedly renders the rollout targets unachievable."

(The Society says the ministry responded by pointing out the figures were applicable only to newly appointed consultants designated to do much more colonoscopy than general gastroenterology).

Comments from anonymous gastroenterologists quoted in the report include:

> *"I think that to roll out screening but have no extra money for increased facilities is putting symptomatic patients at risk."*
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> *"In our DHB we're constantly being criticised about waiting times for CTs and MRIs, as well as access to theatre and waiting lists for elective surgical procedures. To roll out a bowel screening programme in this environment is simply not sustainable."*
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> *"While the importance of the NBSP cannot be overstated, it is putting a terrible strain on doctors and nurses at the DHBs who were already having difficulty keeping up with their workload."*

The number of nurses in endoscopy training was too small to have any impact on the endoscopy workload in the next few years, the report says.

Christchurch Hospital gastroenterologist Professor Murray Barclay, who is also ASMS president, tells *The Specialist* the report puts a much-needed spotlight on the strain in the sector and the society has been assiduous in its efforts to improve the situation.

Canterbury DHB had been scheduled to join the national bowel screening programme in the first half of 2018, but it has been repeatedly pushed back.

"At Canterbury we've been working at or beyond maximum capacity for years. There was no extra capacity to do bowel cancer screening. Other necessary colonoscopies are at risk of not being done when we start."

"So they keep delaying it."

While a supporter of the screening programme, Professor Barclay says the delay is essential as CDHB simply does not have the capacity.

"There are not enough gastroenterologists or endoscopy facilities to do colonoscopy even without bowel cancer screening. "With the screening it's putting a hell of a lot more pressure on every unit and every unit becomes understaffed at that point."

Professor Murray Barclay

AT A GLANCE

Survey results (November 2017):

- 93 gastroenterologists, nine of them only in private practice.
- 1.93 FTE gastroenterologists per 100,000 people; Australia has 3 per 100,000.
- Significant regional, income, and ethnic disparities in access.
- Four DHBs had no gastroenterologist.
- 42% of gastroenterologists will retire in next decade.
- Eight new gastroenterologists trained per year.

COLONOSCOPY ACCESS

Data released by the Ministry of Health under the Official Information Act has revealed disparities in DHB colonoscopy actual volumes versus expected share of the procedures.

IN THE YEAR TO JUNE 2018:	ACTUAL	EXPECTED SHARE
Wairarapa	906	586
Bay of Plenty	3794	2863
Whanganui	1078	826
West Coast	569	440
Lakes	1468	1197
Hutt Valley	1877	1554
Northland	2727	2278
Waitemata	7178	5999
Counties Manukau	5677	4795
Tairawhiti	593	503
Taranaki	1616	1401
South Canterbury	833	795
Waikato	4411	4543
Auckland	4495	4707
Hawkes Bay	1866	1964
Southern	2991	3644
Canterbury	4604	5837
Capital and Coast	2226	2930
MidCentral	1532	2091
Nelson Marlborough	487	1969

MINISTRY OF HEALTH RESPONSE

In a paper prepared for Health Minister David Clark, released to ASMS under the Official Information Act, officials say Scotland is a more apt comparison than Australia for specialist numbers. Matched with Scotland's per population ratio, New Zealand would need an additional 29 gastroenterologists.

Dr Clark's office had requested a ministry briefing about the New Zealand Society of Gastroenterology report.

"The need for this level of increase could be ameliorated due to New Zealand's use of other specialist workforces, for example colonoscopies being provided by general surgeons," the paper said.

The paper says the ministry welcomes the report and acknowledges specialists' concerns about workforce capacity constraints. The ministry's previous efforts have included recruiting from overseas, developing the nurse endoscopy training programme, and the colonoscopy wait time indicators.

Officials proposed the following possible solutions – a centralised training centre to support basic and advanced training, removing barriers to practice to grow the nurse endoscopist workforce, supporting DHBs to create extra registrar training places, and creating gastroenterology wait time indicators with a clearer view of demand over the whole service.

But, it says, the ministry needs more time to consider the report's recommendations.

The paper concludes by saying the ministry will consider a collaborative approach with stakeholders to effect improvements.

Southern DHB, which pushed forward with screening despite resourcing issues, is the subject of a highly critical report highlighting relationship issues and poor clinical outcomes.

Leaked to the media last month, the report concludes that limiting access to colonoscopy had gone too far with adverse consequences for patients. Undue delay in diagnosis or treatment was found in 10 of 20 local cases audited by the reviewers. The reviewers, general surgeon Phil Bagshaw and gastroenterologist Steven Ding recommended the DHB urgently overhaul its management of bowel cancer. Southern performed poorly on measures such as emergency department diagnosis of bowel cancer yet had one of the lowest colonoscopy rates.

"These unfavourable standards indicate that there are serious problems with the control of colorectal cancer in the SDHB population."

"Inadequate resourcing appears to be a major impediment to the SDHB dealing with these problems," reported the *Otago Daily Times*, quoting from the leaked report.

Professor Barclay points out the long-running screening pilot in Waitemata, on which the national programme is based, relied on generous use of gastroenterology locums.

"It worked in Auckland in the pilot scheme as they brought in many staff from other DHBs to cope with the numbers."

Professor Barclay says it's inevitable patient care will suffer once screening is implemented with the current resourcing. In fact, it's "probably happening now but we are keeping a lid on it to a certain degree".

Asked about a well-publicised case of a young mother diagnosed with terminal bowel cancer after being declined for a colonoscopy, Dr Barclay says there are "lots of stories like that", and Southern DHB "will have many similar cases".

"Most people don't make anything of it. You hear one or two make it through to the media, but the vast majority no one knows about."

Professor Barclay does not believe nurse endoscopists are a solution, but says it's a matter of debate among specialists.

"For bowel screening you want your most highly qualified endoscopists, as they are amongst the most difficult procedures."

He says surgeons and gastroenterologists deal with polyps and small cancers as they go and do patient assessments, making the system more efficient. Also, in the public hospital system the cost of the endoscopist is only a small fraction of the overall cost of the procedure.

AFTERMATH OF REPORT

New Zealand Society of Gastroenterology past-president Professor Michael Schultz, a Dunedin gastroenterologist, says a lot of work went into compiling the workforce report, which has been disseminated widely in the sector. A meeting followed with Health Minister David Clark, as well as an invite to a Ministry of Health workforce workshop.

He is feeling confident: "It looks like something is happening".

The society has been working constructively with officials to amend faulty workforce capacity figures. Of figures estimating gastroenterologists' capacity for colonoscopy throughput, he says: "those numbers were off the rockers".

A little-known indirect consequence of screening is a significant increase in symptomatic patients. These are often people too young for screening who have become aware of the symptoms because of publicity around the programme. This led to a 25% increase in symptomatic patients in Dunedin.

"The symptomatic patients are killing us at the moment."

"We are doing so many other things. There are more hepatitis C patients. The community didn't want to treat them so it's on us."

At Southern DHB access to specialists had been severely restricted and after the loss of colleagues and a troubled time in the department: "We are in a crunch".

"We have a fantastic new Dunedin Hospital gastroenterology unit but we don't have any doctors to fill it."

Access has been severely restricted in Dunedin for anything but the most serious cases.

Of irritable bowel syndrome (IBS), he says those patients have no chance of being seen. This is a less serious ailment, but seeing a specialist can be a vital reassurance for patients with unsettling symptoms.

"They want assurance that it is IBS and they can't do anything else. I'm sad we can't provide this - 80% of my patients in private have IBS."

The issues are long-standing and there is no quick fix.

"More locums would be a starting point. But the mistake in the past is the Ministry made available lots of money without a directive. Some DHBs used it for locums to make their waiting list look good but they did not invest in services."

Professor Schultz says that when he emigrated to New Zealand, 14 years ago, he met a German surgeon, who told him he had never operated on so many advanced bowel cancers in his career as during his stint in New Zealand.