

Nelson: A united front

Nelson has a proud history of house surgeons undertaking the Diploma in Obstetrics, and then going into the training program in obstetrics and gynaecology. I was one of them. Ten years ago I returned to Nelson Hospital to work alongside my mentor Kevin Hill. I always remember Kevin reassuring me that Nelson might not provide the big returns and high profile of the teaching centres, but that life as an O and G consultant would provide plenty of challenges and job satisfaction, along with a lifestyle that brings its own rewards.

Nelson is situated at the top of the South Island of New Zealand. It is a well-known tourist destination, renowned for its sunshine, beaches, national parks, wine, and alternative lifestyles. Its main industries include fishing, timber, and fruit. The population of 65,000 continues to grow, and Nelson Hospital now serves the wider community of 85,000 people.

The maternity unit has 1000 deliveries per year and our services also cover 180 home births and 100 deliveries in two outlying cottage hospitals. The demands of the fastest growing population in New Zealand with only two consultants working a one in two roster became unsustainable, so the appointment of a third consultant last year was warmly welcomed. We work under a locally negotiated contract to provide full acute obstetric and gynaecology cover, clinics and surgery. Private practice is an option that is available and is variably taken up by each of us to suit our current commitments.

One of the benefits of working in a regional hospital is the good personal and professional relationship we foster within the

multidisciplinary team. This includes talking over difficult cases, lending a hand to each other in theatre and providing cover to one another. More importantly, we provide support and cover so we can each continue our professional development. Locum cover is always difficult and expensive to find, so our common commitment ensures we can attend conferences and take annual leave. So long as we plan ahead and consult each other, we usually find our roster works out fairly over time. Like all departments we have our own policies and politics that need to be worked through. While we respect our differences, we also recognise the value in finding agreement so we can present a united front when negotiating with hospital management. This process in turn has resulted in a very good working relationship with our managers.

We are mindful of the risks of becoming isolated and failing to keep up to date with new trends and techniques. To this end we are committed to attending workshops and operating together to learn new procedures and running surgical study days with visiting surgeons (for example, we were the first unit to introduce the transvaginal tape procedure to New Zealand by inviting a colleague from the UK to teach us the procedure). Kevin and I continue to be examiners for the Diploma and Membership exams and this helps maintain our participation in education and College activities. I recently extended my participation and professional development at the national level by taking up a position on the Competence Review Committee for the New Zealand Medical Council. This involves another opportunity to observe and learn from other doctors working around the country.

Working in a peripheral hospital means that one must be a jack of all trades. As generalists we enjoy a wide variety of work in both disciplines, but always recognise and value the expertise of our tertiary centres. Our infertility and oncology patients travel to Christchurch (five hour drive, or 60 minute flight), and our perinatal and neonatal transfers go to Wellington (ferry crossing to the North Island, or 30 minute flight). Four paediatricians service our level two neonatal unit, which caters for babies born at 30 weeks or more. Like all peripheral units, the increasing demand on the level three neonatal beds throughout the country often leads to stressful hours trying to secure a transfer of a mother in premature labour.

We enjoy teaching our junior doctors undertaking the Diploma, and we have contemplated hiring a registrar in training, but the Resident Doctors Association requirements to decrease the working hours of our house surgeon has made it increasingly difficult to fulfil the requirements for the Diploma in Obstetrics. The restricted hours have resulted in our trainees having difficulty in gaining sufficient practical experience or enough deliveries to complete their log books. This certainly seems to have contributed to less enthusiasm for our junior doctors pursuing a career in obstetrics and gynaecology.

Getting out of bed at night does not get any easier, but when I ask myself would I do it all again, the thought of that scream of my reel as the mighty trout strikes, confirms that I'd not have it any other way.

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