GENERAL SURGERY

Elective Report

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I carried out my elective placement in a busy general surgical firm in a large district general hospital on the outskirts of Auckland. The department was one of the largest I have ever shadowed at, with 14 consultants, each subspecialising to some extent in areas like liver, breast, or upper GI. The firm I was in had three consultants and specialised in colorectal, upper GI and bariatric, as well as covering other common surgical problems such as fistulae, abscess, leg cellulitis. The firm ran to a similar structure that I've experienced in the UK, with a weekly day of being on take, "admitting", producing the acute theatre lists, and schedules clinics and elective theatre lists.

The level of teamwork and organisation required to run the department smoothly is considerable, and is facilitated by a morning "handback" session in which all new admissions are reviewed and if they have had a previous admission, they are returned to the team that knows them to improve continuity of care. I was aware of patients being referred to and accepted by other consultants informally during other placements in the UK, but for this to happen formally seemed a useful tool for improving quality of care and flow of patients through the department. I witnessed several patients become very well known to the teams and knowing that any patient "belongs" to a team might help the team to be particularly thorough and not to discharge patients who are at risk of readmission.

During my placement I soon noticed certain differences in prescribing between the UK and NZ during the rounds and afternoon ward work. Prescribing errors by nurses and junior doctors in the UK have, unfortunately, been a media staple in the past few years. In 2008 the General Medical Council (UK) commissioned a report investigating the alarmingly highest rates of prescription errors in the National Health System. They found that medication errors were the second greatest cause of inpatient harm, after falls. Error rates were 8% and 10% in first and second year doctors respectively. Problem areas identified included failure to document allergies and prescribing drugs which caused allergic reactions. Using brand rather than generic names has been implicated in this as, for example, class reactions such as penicillin sensitivity, can be overlooked if brand names give no clue as to drug class, e.g. charting Augmenting rather than co-amoxyclav to a penicillin sensitive patient. Another problem area includes decimal places and units e.g. mg/mcg on drug doses.

During the final year of my medical school, we were given a series of workshops on safe prescribing; however this is not a substitute for the hands on experience that trainee interns receive in New Zealand. I suspect they commence work more confidently and able to prescribe common drugs than junior doctors in the UK do. During my placement I was interested to see a new standardised prescription chart being rolled out across the wards. As a

visitor, I had already considered the old charts to be dangerous and ambiguous, and was surprised to see how quickly they could be filled out, and how few safety features that I take for granted were incorporated. Naturally, these seemingly over complex charts represent a change which some juniors at first grumbled about. However, they are much like the new UK drug charts bought in a few years ago specifically to try and reduce drug errors and iatrogenic harm. After getting used to them I found the new UK chart format less ambiguous and better for patient safety. However I would be interested to see if NZ considers banning trade names of drugs in favour of generics.

NZ and the UK have different ways of funding and purchasing medicines. Whilst in the UK one can prescribe any licensed medication, in NZ there are one or two from each class prescribed automatically. A board called Pharmac is responsible for picking which drug this is on the basis of efficacy and cost. If there is a problem tolerating this drug, or it is not therapeutic, than another drug from the class must be requested and authorised, at a higher cost and with more paperwork. I think this is a really great way of both cutting the cost of hospital medicines by allowing hospital boards to bulk buy and create a more favourable purchaser market, but also makes for safer prescribing as doctors, especially juniors, quickly become familiar with standard doses and regimes of important drugs. As a junior, one rotates with different bosses favouring different drugs according to what they have the most experience using. This may be suboptimal, more time is spent looking up doses or rare drugs, and nurses are less used to giving the wider range of drugs so may not realise if the wrong dose has been prescribed.

However on the other hand, junior doctors in NZ seem to rush into writing prescription more quickly, as with fewer drugs to choose from have fewer anxieties about picking the one with the best side effect profile. They have less autonomy as physicians in choosing medicines and so have to think less. In most cases time and money is saved, and juniors prescribe confidently, though more paperwork may be created in the few cases where a drug is not well tolerated. There also seem to be fewer pharmacists patrolling the ward and fewer corrections on drug charts than in the UK. I am surprised a system like Pharmac is not in place in the UK, which is under great financial strain and has an urgent need to reduce costs. Junior doctors are encouraged to know what each drug costs and consider this in their prescriptions; however this can lead to resentment in some as it encourages a rationing mentality on the wards. Some claim this competes with actin gin the patient's best interest. Indeed the British National Formulary (BNF-drug reference book) only recently began including price comparative data. However I feel that if a body of experts, such as those at Pharmac are auditing data and picking drugs with efficacy and long term results in mind as well as cost, that this does serve patients and tax payers' best interests.

I was fascinated to observe several theatre lists with Bariatric surgery during my placement. I hadn't had a change to observe any laparoscopic bariatric surgery in the UK. I enjoyed assisting in several gastric sleeve operations and was impressed by the technique and rapid post op recovery. Both NZ and the UK have high rates of adult and child obesity. The attitudes towards bariatric surgery seem more positive in New Zealand, whereas in the UK, there seem to be more barriers to publically funded bariatric surgery. In the UK, 1 in 4 adults

and 1 in 10 children aged 2-10 are obese. In NZ 1 in 4 adults and 1 in 12 children are obese. However projections of obesity rates in both countries are frightening, and represent a health time bomb. The reasons in both countries are the same and inescapable: increased calorie intake and reduced calorie expenditure. However, within this, further statistics correlate increased BMI to both ethnic minority groups and those with low socioeconomic status. In the UK BMI is linked closely to socioeconomic status rather than ethnicity. In New Zealand both ethnicity and socioeconomic status seem important. Ministry of Health (NZ) statistics show that Maori boys and girls are 1.5 times and Pacific Island boys and girls are 2.5 times more likely to be overweight than averages for the total population.

Whilst the technical skill of the surgeon and the support of bariatric nurses pre and post op are of huge importance, the criteria to receive bariatric surgery involve the patient losing some weight through exercise and diet initially. The patient is ultimately in charge of their lifestyle and the operation can only help those with the will power to use this tool to make changes and stick to them in the long term. I was interested to read a paper from the journal *Obesity Research.* This paper evaluated the self-perception of being overweight in 5540 people of the US, excluding those who had BMI less than 18.5.kg/m2. They compared self-perception of being overweight between White, Black and Hispanic groups and according to sex and socioeconomic status. The characteristics of those more likely to correctly perceive themselves as being overweight were being female, white, educated and of a higher socioeconomic class. This reinforces the importance of ethnic, socioeconomic and cultural consideration in identifying those who might benefit from bariatric surgery the most. It would be interesting to see how self perception correlated demographically in New Zealand. Health providers need to encourage targeted education about healthy weight and improving unrealistic perceptions about ones own weight such that poor self perception does not bias access to services from those who could benefit most from them. If they are to succeed in their drive to improve Maori and ethnic minority health, education is needed to encourage people to access services according to need, rather than economic status. It seems from the many hospital posters, patient leaflets and TV adverts that this education is being seriously attempted; the success of this approach is vital for the future of New Zealand's health and reducing the inequalities within it.

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Sex, Race/Ethnicity, Socioeconomic Status, and BMI in Relation to Self-Perception of Overweight

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