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OPHTHALMOLOGY

Elective Objectives

1. Pattern of disease of the population and global health

General ophthalmology in an affluent city with significant ethnic minority populations (approx. 45% in total). How is world health changing, as the world industrialises and develops more 'diseases of the rich', in addition to their own disease patterns?

New Zealand is a developed country, home to around 4 ½ million people, a third of which live in Auckland. Auckland's population is mainly Caucasian (approximately 60%), but also Māori (10%) and, more recently, East Asian (20%) and Pasifika (non-Māori Polynesian) (15%); this mix presents a wide range of genetics, risk factors and cultural/behavioural patterns, which can then affect demands on health services.

One example is that of Type II diabetes and its complications: the provision of medical retina specialists was proportionately larger than I had seen in the UK, and both diabetes and obesity (especially morbid) are more prevalent in Māori and Pasifika groups.

Minority groups also suffered more from sight-threatening pterygia, but this was thought likely to be due to the life-time exposure to UV light at lower latitudes prior to their arrival in New Zealand. Whereas pterygia are rare in the UK, removing those impeding sight occupied full surgical lists here, and their presence was not uncommon as an incidental finding.

However, the most significant pattern, which seemed to cross all cultural boundaries, was that of later presentation. A greater proportion of cataracts were mature enough to be brunescent at the time of both surgery and presentation than in the UK, an observation corroborated by the British-trained associate professor. This posed additional difficulties – phacoemulsification took longer and conversion to extracapsular extraction was made more likely. However, the most extreme cases were anecdotally found in minority groups, perhaps due to a combination of language barriers, lack of familiarity with the system and advancement prior to arrival.

2. Pattern of health provision, compare and contrast with UK

Compare and contrast the private/public health system in NZ, the first in the world, with that of the UK currently, with its predominant NHS model, and how each might learn from the other.

New Zealand was the one of the first democracies to nationalise its health system, in 1938 before the UK. However, a combination of rising costs and a contraction of the NZ economy in the 1970s led to a series of reforms of the next two decades, leading to the current, mixed public—private system of today, a path that the UK may be following.

Patients must pay for a visit to a GP, but this is subsidised according to income. Patients must in general also pay for their prescriptions according to market cost, although the government agency PHARMAC lists approximately 2,000 medications that are either fully or partially subsidised. Free elective surgery, such as much of ophthalmology, is rationed through 'requests' to be put on waiting lists and assignment to categories of priority, and patients are aware of the possibility of rejection. These criteria are freely available to the public as a matter of transparency, and the more restricted extent of drug subsidy is coupled with the prescribers' option to prescribe outside the PHARMAC list, should the patient wish, after discussing the options.

These aspects seem to correlate with several differences between NZ and the UK:

- A greater tendency to seek help *via* Emergency services (which are fully paid for by the government) rather than GP, something that even in the UK is a costly problem,
- A greater acceptance of the limitations of government funding, as opposed to the UK aspirations of supplying practically all services free-at-point-of-access,
- More widespread use of health insurance and private practice, particularly for elective procedures, which in turn is dominated by charitable suppliers such as Southern Cross Healthcare.

However, New Zealanders appear to credit the UK system with greater efficiency, i.e. health outcomes for money spent. However, PHARMAC has acquired its own good reputation for restricting the costs of pharmaceuticals in New Zealand. There also remain comments about the cost restrictions in public healthcare (as in the UK), but also the aspect of staff retention, since a thriving and proportionately larger private sector can offer an alternative career to many in the public sector, rather than in the UK where the impression is of an additional source of work to NHS work to all but the very few and the semi-retired.

Finally, it is not clear to me why New Zealand seemed to greatly out-perform East London in provision of translators: every patient I saw whose English was not sufficient to communicate with the staff was provided with a professional translator from reception to the end of their visit and, furthermore, the patients' families did not need to perform ad-hoc translation of often-difficult concepts. Given the concerns of confidentiality and the effect of the attendance of family on consultations that are known in the UK, it would be interesting to know the reasons behind the difference in provision.

3. Health-related objective

To improve my understanding of eye health issues, their examination, assessment and treatment, my skills in basic techniques (e.g. slit lamp, IOP measurement) and diagnosis, the connections to general health and patients' ideas, concerns and expectations upon entering a rather niche specialty, and what research might hold for them in the future.

I had three main objectives in New Zealand:

- to further investigate the career option of ophthalmology, the specialty which is currently my primary career choice,
- to learn in an ophthalmology environment less specialised than Moorfields, to give myself more general skills, understanding and an appreciation of more common patterns of eye disease and
- to experience healthcare training in New Zealand, which would extend my training opportunities beyond the UK.

Despite the great deal learnt in Moorfields, Auckland extended my skills due to their willingness to teach and the patients' openness to be learnt from. For example, as a result I now feel superficially competent in assessing the fundus with a slit lamp and lens, and IOP *via* Goldmann tonometry. Further than that, I have acquired a more solid understanding of ophthalmology in practice and understanding of how and why certain signs are observed, especially in corneal pathologies, no doubt due to Prof McGhee's specialism and great interest in teaching others.

4. Personal/professional development goals

To experience and learn from ophthalmology practice in an advanced but comparatively isolated country, meet professionals working with ophthalmologists to experience their side of care, explore a country at once close to and far from the UK, and reflect upon the services needed and most valued by different groups, and how they are accessed.

The practice that I witnessed seemed to differ little from UK bar certain important aspects:

- Travel to and from the clinic was far greater, as although far smaller than Moorfields with fewer patients, the area served was far larger (much of North Island and beyond). However, the patients were, conversely, far more used to long-distance travel to see a specialist, some coming from outlying islands such as Fiji or Niue, and many often flying to Australia or the UK. These aspects necessitated a more accommodative booking of follow-up clinics.
- I felt there was more evidence of a 'can-do' attitude to procedures, possibly influenced by the difficulties of travel for some; procedures such as injection of anti-mitotics or certain, relatively minor procedures would be fitted into lists or even performed in-clinic almost on the spot.
- Conversely, certain rules were not as strictly adhered-to, such as washing hands. One British-trained consultant felt that these last two were linked; he felt that there was more of a spirit of professionalism with more freedom, but conversely that the UK could implement uniform top-down policies more effectively. It would be interesting to see whether such differences make a significant difference to patient care, for better or worse.

There was also a more collaborative approach between optometrists and ophthalmologists both within the department and between the department and 'high-street' optometrists providing primary care. There seemed an expectation of high-quality information in referrals from outside optometrists, and in

their turn the department aimed to return the favour with adequate imaging and photographs when optometrists were asked to take over monitoring of certain conditions.

The collaborative approach between consultants and their juniors was impressive; second opinions were frequently sought and received over the course of clinics, from management plans to patient assessments, and the attention of seniors may well give patients more confidence in juniors' decisions.

However, due to NZ's retention of the post of SHO in the form of non-training registrars (NTRs), ophthalmology training time is reduced to 5 years (rather than the British 7) and anecdotally, this made other specialties consider ophthalmology training to be particularly arduous, although the registrars I met made no complaints and seemed happy with their choice. This also seems to be reflected in the competition for training positions; where once there were few who wished to train in the specialty, ophthalmology in New Zealand now prides itself in being one of the most competitive specialties.