CHRISTOS MIAMICIOTIS RESPIRATORY

I have always wanted to visit New Zealand and the final year elective gave me the opportunity to explore the subjects of my interest in New Zealand's capital, as well as travel around to see this beautiful country. The objectives set for this elective by my medical school coincided, in a way, with the objectives I set out for myself while out here in Wellington. In the last couple years of my medical degree, I developed an interest in both the respiratory and gastroenterology specialties of medicine. As a result, this influenced my decision to try and secure a hospital placement in either one or both of these specialties and I have to admit I have been lucky in doing so. Coming from the UK, I didn't really know what to expect in terms of patterns of disease and what is common and what not in this side of the world. One would expect that being in a Westernized country, New Zealand's health professionals would be dealing with patters of disease similar to that of the UK. To some extent that is true.

However, at least for the specialties I have seen, there appear to be some differences which I believe have to do with both the health system which is in place here as well as the different populations that exist here. On a respiratory ward in the UK, one can expect to find a few patients with COPD, asthma, pulmonary fibrosis and pneumonias (especially in the winter months). In Wellington, most of the respiratory patients I have seen suffer from cystic fibrosis and lung malignancies. It seems that COPD and asthma are dealt with in the community or by the general medical teams and are only referred to the respiratory team once quite severe. There are very few patients under the care of the respiratory team and these are the ones with the more complex problems and co-morbidities such as patients with cystic fibrosis, sarcoid etc. There are clinics running every day and lung function testing is very big here for both inpatients and patients coming to clinic. Similarly, for gastroenterology there are OGD and colonoscopy clinics every day, follow-up and new patient's clinics very often and inpatient care usually follows referral from the medical team. Community based management appears to have a major role here, and that is why perhaps GPs are also paid by the patients as well as the system. The number of inpatients for at least these 2 specialties is very different to the UK. From my experience in the UK hospitals, there are usually a couple of inpatient wards for each specialty, in some places for different genders, which can accommodate between 20-25 patients at a time. As a result, there exists the possibility of having 40-50 inpatients per specialty. It is obvious that the workload of all professionals involved can appear greater as opposed to our New Zealand colleagues which can have 1-2 inpatients at the same time! I was very surprised to see that in 1 day there might not be a single gastroenterology patient in the hospital and maybe 3-4 respiratory patients! Also, there are no designated gastroenterology or respiratory wards but general medical wards where patients of various specialties can be found. As a result the team of doctors involved in the care of such patients is a lot smaller. In a UK hospital, a gastroenterology or respiratory team can include 7-8 consultants, 4-5 registrars, 3-4 senior-house officers and 2-3 FY1s. In New Zealand, one can find 4-5 consultants, 1-2 registrars, 1 house surgeon (equivalent to SHO) and 1 trainee intern (at the level between final year student and FY1). This, of course, is not absolute but it is obvious that large numbers are not necessary if there are not that many patients. It appears that a lot of the care is community/GP based and people will come or be referred to hospital if entirely necessary. As a result, hospital based doctors have more time to complete other tasks to enhance their CV and knowledge such as focus more on research and complete audits. Also, it allows more time for teaching and I have witnessed medical students attending consultant led bed-site teaching a lot more than in the UK.

Unlike the NHS back home, there are various health systems in place. For example, pacific islanders use the pacifica system and attend specific hospitals. The problem with this though is that once someone ends up in a hospital where they are treated as a new patient, it becomes very difficult to get hold of their previous records and investigations as the collaboration between different systems and hospitals is not great. In addition, I was impressed when I found out that doctors and medical students are expected to have a different approach when dealing with pacific island or Maori patients. Students are taught and are expected to complete assessment and case studies with history and examination of Maori patients in which a different set of doctor qualities need to be employed. Depending on the patient's background, doctors might be expected to disclose information regarding themselves in order to build a rapport and gain the patient's trust. At the same time, these patients expect to be asked questions regarding their tribe or which island they are from, why they came to

New Zealand etc. It seems that a more in-depth discussion takes place. Finally, in terms of my objective to get as much clinical skill practice as possible, I have to admit I did find it somewhat difficult because of the lack of patients in the teams I was working with. However, various team members were more than eager to help me and I have received one-to-one bedside teaching with both registrars and consultants where I received constructive feedback to help with my practice. At the same time, I was allowed to attend teaching sessions prepared for the local students. What I found the most useful, though, was the freedom that I was given to do my own work, find the patients I wanted to examine and generally be my own boss so I could get the most out of my placement.

Christos Miamiliotis