Dunedin Hospital in New Zealand

With the generosity of the Jewish Medical Association, the Ferdinand Beck Fund and the Vandervell Foundation, I completed my medical elective at Dunedin hospital on the stunning south-island of New Zealand. Not only did I have the opportunity to witness first-hand working life in a hospital on the opposite side of the world, I also experienced living in a completely different city to London and had an incredible experience.

I stayed in an Airbnb situated in Ravensbourne - a small hilly suburb just outside of Dunedin city. It was a beautiful and tranquil place which overlooked the Otago peninsula.

My daily routine would consist of a daily board meeting which took place at 7.30am, where all the patients on the service as well as any developments overnight would be discussed. This was followed by the consultant led ward round, where the medical team of doctors would review the inpatients and their management plans. In stark comparison to London hospitals, there were usually only 3-6 patients on our service, meaning that extra time could be spent with each patient, and more thought could go into their management. The ward round was followed by a discussion with the registrar and house officer of the jobs that needed to be done for the day, which may include consenting patients, making referrals and taking bloods. My afternoons would consist of attending clinics, teaching, observing procedures, or clerking in elective admissions.

On the ward, I was also able to practice clinical skills such as taking blood and insertion of intra-venous lines. Fortunately, the equipment was identical to that in the UK - so this was one less hurdle to overcome! I was also fortunate enough to watch paracentesis (drainage of abdominal fluid) being performed, for both diagnostic and therapeutic purposes. The patient had a background of non-alcoholic fatty liver disease (NAFLD) and had noted a drastic increase in abdominal fluid over 3 weeks, which was significantly limiting her mobility and quality of life. I watched as the registrar inserted her first ascitic drain in over 4 years, and I helped out wherever I could. Practically, I provided some

assistance – helping to prepare the equipment and providing an extra hand during the procedure. In addition, I chatted to the patient, trying to ensure she was as comfortable as possible during the procedure. Afterwards, the patient opened up to me about how stigmatised her diagnosis of liver disease was in the community and how difficult it was for her to have people assume her condition is a result of heavy alcohol use.

I reflected that although there are currently many clinical skills that I feel unconfident and uncomfortable performing, this is the nature of what being a doctor entails. The registrar was mildly apprehensive about performing her first paracentesis in 4 years with new equipment that she was unfamiliar with, however I admired her confidence and willingness to perform the procedure despite this.

As well as partaking in ward activities, I also had involvement in research whilst at the hospital. With the assistance of a consultant nephrologist, I am writing a case report on a patient with a unique genetic abnormality of a calcium sensing receptor in the kidney, who underwent renal transplantation.

Another highlight of the elective was being part of the trainee intern programme. The system in New Zealand allows for a year of paid shadowing after completion of medical final exams, something they call 'trainee intern' (or TI) year. The TIs essentially have a similar role as a first-year doctors in the UK, but with considerably less pressure and responsibilities. They're not allowed to prescribe, and they are expected to only manage one third of the patients on their service. In essence, this year eases them from medical school into the real world of medicine, making the step up seem a lot less intimidating. I enjoyed participating in the mandatory daily tutorials that were led for the TIs, on a range of topics from radiology to obstetrics and gynaecology, as well as getting to know them on an individual basis.

In regard to my clinical experience, a variety of pathologies were encountered during my placement. Inpatients presented with a range of conditions, including non-alcoholic fatty liver disease, exacerbations of inflammatory bowel disease, malnutrition secondary to extensive bowel surgery, alcoholic liver disease and upper gastrointestinal bleed – similar pathologies encountered on the wards in the UK.

On one day, there were two inpatients with decompensated liver disease - both presenting with ascites and both of a similar age. Their management and prognoses, however, were extremely different. Patient 1, with early-stage liver failure secondary to NAFLD, was being considered for liver transplant, while patient 2, with end-stage alcoholic liver disease, had a palliative management plan. It was interesting to see the huge difference in outlook for these patients, at opposite stages in their journey.

In clinic, I saw patients with hepatitis C, with an estimated 50,000 New Zealand chronic sufferers. After adjusting for the population size of these two countries, hepatitis C is more than 3 times commoner in NZ than in the UK. In NZ, hepatitis C is the leading indication for liver transplant, while in the UK it's the 2nd commonest cause - with ALD being the leading cause. I also met patients in clinic with chronic hepatitis B – the commonest type of hepatitis in NZ, with a prevalence of 100,000; significantly higher

prevalence per unit population than in the UK. Interestingly, hepatitis B is also the leading cause of cirrhosis in the Maori population.

On my weekends I was able to explore some of the beautiful scenery that New Zealand offers. A highlight was driving up to see the Albatross colony at the tip of the Otago peninsula – the only mainland breeding colony of Northern Royal Albatross in the world. I also visited the Moeraki boulders, which are large round rock formations which took millions of years to form!

Abigail Pomeranc

QMUL