The Royal Victorian Eye and Ear Hospital – Melbourne, Australia

My elective was in Ophthalmology at the Royal Victorian Eye and Ear Hospital in Melbourne, Australia. This is a tertiary referral centre for ENT and Ophthalmology in Australia with specialist clinics and a 24-hour emergency service for the State of Victoria.

My elective experience was a unique opportunity for me to learn about the clinical skills and expertise necessary to perform as a doctor. An integral skill in being a doctor is communication. Throughout my time at the Royal Victorian Eye and Ear Hospital I met people from many cultures and nationalities.

About 30% of consultations were not in English so it was crucial for me to learn how to communicate with an interpreter present in the consultation. I drastically improved upon my non-verbal communication such as drawing simple diagrams to help patients understand their disease. I believe a patient should always be given the opportunity to understand what their disease is as this helps when the patient has to decide what treatment options should be chosen. When I am a doctor in the UK, I will always try my hardest to inform patients about their disease, even if it is difficult to communicate this.

Another important thing to learn was the clinical examination of ophthalmology. I slowly built up my examination skills using the slit lamp. Through determination and a very supportive network of colleagues at the hospital I was finally able to examine the anterior chamber of the eye. Not only this, I was also able to use lenses to visualise the retina, which is an advanced skill. This progress really emphasised to me the important values of teaching and teamwork. I felt like an integral member of the team and was shown respect and belonging. This made me feel determined to improve upon my skills and achieve to the best of my ability.

It was also important for me to learn how to diagnose ophthalmological disease by logically working from a focused selection of symptoms and signs attained from the history and examination. I was in fact running my own clinics in the Emergency Department, which was an amazing experience. Yet the most important thing I learnt was not the fascinating diseases or patients that came through my door; it was learning when to say 'I don't know'. There were many times when I did not know the answer or felt thrown into the deep end. Fortunately, I was supported by a network of colleagues and was not scared to say 'I don't know'. There will always be a time when one will not know the answer to the diagnosis or cause of a disease. What is important is to know one's own clinical limitations and to ask for help when this occurs. It also emphasised to me the role of teamwork and how crucial it is to learn from your peers. In fact 'I don't know' taught me more medicine than any other phrase on my elective!

One aspect that drew me to Australia was to explore how the cultural and social perspectives of eye health differ in Australia compared to the UK. I was particularly interested in the noticeable healthcare discrepancy between the Indigenous (Aboriginal and Torres Strait Islander) and non-Indigenous people of Australia.

Indigenous people are six times more likely to be blind compared to non-Indigenous people. Extraordinary, Australia is the only developed country where the rare tropical eye disease Trachoma has not been eradicated. The Indigenous people suffer the brunt of this disease with some populations showing infection rates of up to 25% in Central Australia. This is a hugely interesting phenomenon and I wanted to investigate how this can be the case in a country that rates the second highest in the Human Development Index in the world.

I learnt that socially, the Indigenous population have been discriminated against since the Europeans colonised Australia. Many atrocities occurred with the Indigenous population being killed and forced to give up their land. Even up to the 1970s the Australian government took Aboriginal children from their original families and moved them to white households for assimilation. These children have been named by the Indigenous as the 'stolen generation'. An official apology from the Australian government was only issued in 2007. Naturally there is a great deal of mistrust between the Indigenous population and the Australian government – which is a plausible factor as to why Aboriginals have a poorer access to healthcare.

In response to this, the Australian government in conjunction with the University of Melbourne initiated a programme called 'Closing the Gap for Vision' in 2008. The aim of this programme was to eliminate this discrepancy by 2020. This was to be achieved through outreach clinics, education programmes and service changes to increase Indigenous healthcare access.

Locally at the Royal Victorian Eye and Ear Hospital there is a drive to make sure services are accessible to the Aboriginal population. I had a meeting with the Aboriginal Health Liaison Officer at my hospital to understand the protocol at the hospital. He explained if a patient identified as Aboriginal they are put on a separate pathway in the hospital system. For example, they would be assigned a personal Aboriginal Heath Liaison Officer who is of Aboriginal status themselves. These officers will contact the patient a couple of days before the appointment to make sure these patients attend and don't get lost in the system.

In addition, Aboriginal patients have access to free transport to and from the hospital as many Aboriginal patients can live over 100km away. Because Aboriginals have a lower outcome than their European counterparts, they are seen as a priority for surgery. The normal waiting time for cataract surgery is 13 months. If one identifies as Aboriginal the surgery will be performed within 30 days. Therefore it is very important to identify Indigenous patients at the beginning of their treatment.

I was able to meet many Aboriginal patients and interviewed them on their thoughts on hospital access and healthcare. When speaking to patient JM, she explained to me the awful conditions her family grew up in the Northern Territory. She was pulled out of school at 12 and forced to work on the farms by the government. She resented the government and how they mistreated her. She found it very difficult to socially interact with 'whites' and it was very eye-opening to understand the level of poverty she had been through – with 8 children all sharing the same room. It made me realise that poverty is a major factor that contributes to poorer access of healthcare. When I am a doctor in the UK, I will never forget how poverty can affect my patients and will always try to help increase their access to healthcare to the best of my ability.

I wanted to get involved further in the eye health of the Indigenous people and managed to organise a small project in improving the local service. A national strategy had been adopted 2 years ago by the hospital that all patients would be asked if they identify as Indigenous before every appointment. This was because it was so important to identify those who are Aboriginal to get them onto the priority service.

A recent audit showed that receptionists were only asking Indigenous status to 3% of patients coming in for an appointment. This is obviously extremely low against the national standards. I was therefore asked to commission a survey to be sent to all receptionists in the hospital as to why 'The Question' was not being asked and to help tailor a training module for staff to correctly identify Indigenous patients.

In this survey I asked when administrators believed they should ask a patient about their Indigenous status. Then I also asked why they wouldn't ask a patient about their status. The results showed that there were multiple reasons why staff did not ask 'The Question'. The most common was that a patient's nationality made them unlikely to be Aboriginal which can be seen as valid as a patient from China is unlikely to identify as Aboriginal. However, other reasons included lack of time and being uncomfortable in asking 'The Question' due to 'backlash' from non-Indigenous patients. It is very important to address these reasons in a follow up training module for staff.

On reflection, the project really emphasised to me how much work needs to be done to identify who are Aboriginal patients. It is no good having a priority service if Aboriginals are not being identified at the very beginning. I have learnt that improving access to healthcare also involves the clerical staff. I understand what a crucial role these people have in a patient's journey in the healthcare system and how important it is to keep clerical staff updated and informed about national and local guidelines. As a doctor in the UK, not only will I support my patients, I will also support my colleagues – in particular my non-medical colleagues who perform an equally crucial role in the hospital.

Overall, I have learnt so much from my elective and I thank the Royal Victorian Eye and Ear Hospital, UCL and the Jewish Medical Association for giving me this fantastic opportunity.

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