

Elective Report : Vincent McCaughan

Haematology Department
Dunedin School of Medicine
University of Otago

My initial "goals" set before coming to New Zealand were about comparing care in the UK and in the New Zealand healthcare systems, particularly focusing on Haematology. However this was a little short sighted of me as I have limited experience of tertiary Haematology in the UK. I am able however able to look at the different patient interactions and difficulties (and similarities) that are seen here in New Zealand that are not encountered in the hospitals that I have been trained at in the East End of London.

I have been based on the Haematology ward of Dunedin hospital. There are two main types of patient that are seen by the haematologists. The inpatients, these mainly consist of patients who have recently been diagnosed with either a leukaemia or lymphoma or have been admitted for management of side effects of chemotherapy, most commonly neutropenia. The second group is patients who are managed as out patients – there are two main types: those who have had previous haematological malignancy and are in remission and those with blood dyscrasia (such as von Willebrans or Haemophilia).

The haematology team is usually looking after between 6-10 patients most of which are on chemotherapy either having become neutropenic or waiting to become pancytopenic following treatment. Whilst the neutrophil count is still high enough these patients are free to leave the ward during the day and some times over night if the counts are sufficiently high, but once the neutropenia kicks in (as is desired) the patients are confined to their room under neutropenic precautions. As the haematological malignancies can strike the very young right through to the very old there is no generic patient.

Firstly looking at the similarities between the hospital care systems. The New Zealand system for tertiary hospital based care is basically free at the point of access similar to the NHS system. The main difference is that there is a large secondary market for health insurance schemes that can be used in the case of a long waiting list, for example, for a complex operation. This however is very rarely seen in the haematology department as due to the serious nature of the diseases the patients are admitted and treated immediately.. It may become more of an issue with expensive and new medications and chemotherapy regimens.

Another major similarity between the systems is the regulations that govern the management of the patients. Many of the New Zealand guidelines for treatment of haematological disease are based on or are identical to the UK guidelines. There is also some guidance taken for the WHO and from Australian and North American protocols. The reason for the use of the UK guidelines is mainly due to the similar populations but also the larger number of patients in the UK that allow for more statistically significant numbers for analysis.

One major difference that is immediately clear from the hospital is that there is a much larger number of staff to patient ratio. More nursing staff and also more medical staff. Both the Doctors and Nurses on my ward who have worked in the UK feel that there is much more opportunity to provide patient led care in this environment. I feel that this is accurate with more time being spent with patients from both the nursing perspective and from the medical teams perspective. I could also see that there was a considerable amount of empathy and thought put into the care for the patients particularly looking at their life outside hospital.

The treatment of haematological malignancy is a place where the patient is supported by a true multidisciplinary team. Not only are the patients cared for by the doctors and nurses on the ward but in the team there is also: a pharmacist who makes up the complex chemotherapy regimens, a counsellor who deals with the emotional needs of the patient and their family; the microbiology team that advises on the weird and wonderful bugs that can present in the immunocompromised patient; the palliative care team; the social worker; the physiotherapy team. *dietician*

One very large difference between the UK (certainly in NE Thames) and New Zealand is the size of area that the tertiary referral team covers. Patients can come to hospital from over 300+ km away and as a result of this and their likely prolonged stay accommodation is required for relatives who stay for support. This also means that the tertiary team must stay in close contact with the very small single ward hospitals in the patients area. Another consequence of the size of area that the hospital covers is that when something stops working (as the machine that measured methotrexate levels did) the samples have to be sent over 400 km to the nearest (Christchurch) lab.

The treatment of haematological malignancy throws up many problems and ethical dilemmas. Will the treatment kill the patient before the disease? Is the patient suitable for transplant? Is there a match in the family or on the world wide donor register, Will it be better for the patient to choose not to be treated? A major dilemma that I saw on the ward was about asking the sibling of a patient with ALL relapse if they would be prepared to donate marrow. It was clear that the child of 12 was not keen on needles and initially not keen to go through the trauma of bone marrow biopsy.

It is clear to the objective (adult) eye that there may be issues further down the line if the sibling either does (and is not a match) or does not (and never finds out if they could have saved their sibling). The family of the patient said "we have been working on him" understanding that he may be the best hope to save their daughter but it is the responsibility of the clinician not only to look after their patient but also ensure that the minor is not coerced (by a well-meaning family) into doing something that they do not want to do.

Finally I would like to comment on the patients that I have seen over the last few weeks. I have found it inspiring that people can maintain such optimism and dignity in such a difficult time. Despite their diagnosis or treatment or state of sickness they have all taken the time to talk to me both about their medical problems and about life in New Zealand in general. They have been cheerful and positive despite the daily trials and tribulations thrown at them on a daily basis.