Impressions from a foray into Kaitāian medicine

Benjamin Booker
School of Medicine
Faculty of Medical and Health Sciences
University of Auckland

Benjamin Booker is presently a final-year medical student at Whangārei Hospital, where he divides his time between superficially appearing to be vaguely useful and accidentally standing in the path of fast-walking surgeons. He found himself studying medicine following studies in classical piano performance from Victoria University, and has a particular interest in politics and philosophy.

While many people who enter medicine do so from a strong, if vague, inclination to make the world a better place, it proves remarkably difficult to articulate the exact role of a doctor in a society where we no longer just cure disease – where letting die, for example, may be kinder than stoking the perishing embers of a well-lived life. It is even harder to hold to this altruistic inclination amongst the competition, theoretical memorisation, hierarchical machinations, and existential weariness that medical school invokes; perhaps hardest of all is retaining the ability to truly see people walking through the doors, when the temptation is to see chest pains, broken femurs, renal failures, and smokers in order to find temporary solace from medicine's encroachment on our time and, more taxingly, our hearts.

It is tempting too, to get swept away amongst the bravado of the latest magnetic resonance (MR) scanner or the most powerful immune mediator, but behind the awesome forces of investigative diagnostics and sci-fi treatments remains an old truth: the powers of clinical endeavour amount to very little when compared to the powers of a patient to heal himself. Nowhere in my training over the last six years have I seen this principle upheld to such an extent as it was during two placements in rural generalism and general practice in Kaitāia. As such, these placements served as a worthwhile reminder of higher motivations in medical study and challenged me in a more urgent way to consider patients once again as people complete with their own particular vibrancy and complexity, as well as their own medical trials and triumphs.

Kaitāia is a town that has seen great successes and challenges in hauora, with a relatively high level of deprivation, comorbidity, and social difficulties. The urbanisation of industrial and manufacturing jobs has added to the high unemployment rates and Te Tai Tokerau in general appears to receive promises triennially around election time that vanish quickly in the shadow of Auckland highways and ostensible 'tough economic times'. Generations of cultural marginalisation have left many Māori in the region with systemic barriers to maintaining tīkanga of profound significance; however, the loss of traditional fabric has not been met with adequate governmental support to replace it with a new fibre of hauora whānau to weave from. Be that as it may, the people are exquisitely welcoming and friendly, the landscape raw and beautiful, and the rush hour completely non-existent.

The physical health challenges are also slightly unique. Rheumatic fever, erased from most Western undergraduate courses, snarls away despite the enterprising efforts of telehealth teams, as do chronic skin and lung infections. For many, the name Kaitāia – literally 'ample food' – is grimly ironic. And perhaps underlying most adolescent consultations is the practitioner's awareness of the region's smouldering underbelly of suicidality, which periodically ignites into a powerful and horrible explosion of destruction, directed within, but devastating many without, too.

Kaitāia Hospital's status as a rural hospital means it is unable to maintain computed tomography (CT) or MR scanners, full-time specialists, round-the-clock laboratory or radiology access, specialised blood tests, or advanced treatment units. In lieu, however, it has some of the more impressive communicators, general diagnosticians, and even, if patient reports are to be believed, hospital meals that this country has to offer. Like many rural hospitals, it practises a type of medicine which I had envisaged (before medical school) would be the norm – a practice based on a flexible broad-based clinical knowledge with the option of pursuing further interest areas in greater detail, and where the doctor takes an active interest in the long-term and general health of her patients and society. There is also an active interest in cultivating multi-disciplinary relationships and understandings, and also a collegiality with general practitioners, rather than the more common 'professional separation' – perhaps often used as euphemism for 'private condescension'.

A typical day in the hospital medical team consists of a morning multidisciplinary handover, followed by a ward round of the entire hospital with the medical and nursing staff. Such an effort necessitates caffeination before setting to work completing morning paperwork and

ward jobs. The rest of the day usually entails clerking and admitting or discharging patients from the emergency department and performing therapeutic procedures if required.

Rural general practice differs from the urban practices, too. Late presentations, combined with a characteristic staunchness and sometimes a poor understanding of the possibilities of medicine, appear to create a subset of patients who do not expect to reach retirement age – generations of early familial deaths, it seems, have convinced many that their fate cannot be different. As such, much hinges on the integrity of the therapeutic relationship as well as clinical rigour at each visit, no matter how rare the visits may be. After all, in a community of this size, it is not at all unlikely that the mother of a practitioner hears of a misdiagnosis before the practitioner himself does!

Since the emergency department is the first port of call for a relatively wide catchment area, a correspondingly wide range of cases find themselves presenting through its doors and with them, the responsibility to assess whether more severe cases can be managed on site (with or without specialist help from Whangārei or Auckland) or sent elsewhere by ambulance or helicopter. The absence of CT scanners often makes initial clinical findings and their formulation crucial, and offers a useful reminder of the importance of a good history-taking and examination technique (dare I say 'proper' medicine?), which is also on display after business hours when laboratory and radiological staff are on call, and decisions about the necessity of further tests need to take into account the potential wrath of a sleepless radiologist faced with a gratuitous request.

The effects of this in a more chronic setting are worth consideration. All the doctors I worked with had beautifully refined their natural talents in discussing palliative decisions with patients and one factor involved was the toll of constant travelling on the quality of the last days of life and whether this would negate any perceived benefits of intervention. Similar issues apply to operations or specialist appointments booked in larger cities. All this, I suppose, is raised more to illustrate the capabilities and admirable achievements of Kaitāia's health service with comparatively sparse specialist resources on site, than to emphasise its medical remoteness and to show what a privilege it is to learn from the practice of doctors whose clinical acumen and thoroughness is at a premium.

A premium was also placed on a slower unshrouding of social history. It was maybe the first time I have seen whakawhanaungatanga put properly to practice – where 'where is your family from?', for example, is used as a means of building social connection through shared experience rather than emphasising difference. Discussions about depression and death, then, were an unfurling of a tapestry of experience and perception, rather than identification of symptoms and formulation of treatment. While this really is not any particular revelation theoretically, its translation to practice is surprisingly rare – and the habits and role-modelling that junior doctors receive in some bigger hospitals undoubtedly perpetuate old practices, even when modern ideas may be taught in theory.

Another interesting aspect of the selective was the opportunity to see the impressive work of community organisations. I spent a day with iMoko, a telehealth company providing remote diagnosis and prescriptions for those such as children with superficial skin infections, sore throats, or headlice. In this way, some low-complexity medicine can be practised by communities in their own settings, while still by and large maintaining the speed and accuracy of treatment in a clinical setting. Another day was spent with the nurses in the B4 School Check programme, checking children for gross health, vision and hearing, co-ordination, and spatial skills. This offered an insight into health promotion separate from the more downstream interventions that we more often practise at the hospital. I was fortunate enough to get a chance to join the St John's paramedics for experiences in the ambulance and helicopter. This was yet another chance to see health care out of the doctor clique, where redoubtable skills in patient stabilisation take priority over tests and plans. One memorable case entailed collecting and delivering to Auckland a woman who had had a large heart attack in the middle of a church sermon. I will leave the reader to adjudicate the aetiology of this event.

At this level of training, my impression is that successful learning in clinical practice does not usually consist of a series of quantised lightbulb moments, but rather a series of normal moments viewed in a new light, stimulating the slow formulation of a new perspective on patients and oneself. While I cannot predict where my medical journey will take me to, I know that throughout the trip I shall look back on my time at Kaitāia as one of these special turning points, where people in hospital beds and their situations were able to be seen with a new acuity. Perhaps this is all to say that if the reader should find him or herself with a sort of existential fibrous pericardium induced by medical school, where protecting an idealistic heart from disillusionment and emotional ischaemia has left it slightly subdued in passion and joie de vivre, a selective or general practice placement in Kaitāia may be just the tincture the doctor ought to order.

Acknowledgements

Sarah Clarke, Joel Pirini, Kath Rollo, Kevin Rodgers, and all the Kaitāian health care team.