Viewpoint

Six months in New Zealand

It was surprisingly easy to arrange an exchange of medical duties with my old colleague from Guy’s, Dr Hugh Burry. He came to live in my cramped suburban house with its patch of lawn. I went to dwell in his hillside bungalow near Wellington, surrounded by 12 acres of steep farmland, sheep, chickens, and a bulky steer. For 6 months I learned to perform the sundry tasks associated with rural life in New Zealand. When not admiring the view across Cook Strait, repairing the farm truck, clearing mudslips, or chopping firewood, I practised rheumatology at the Regional Centre for Rheumatic Diseases and taught medicine in the Wellington Clinical School.

During such a short period it was impossible to gauge the achievements and problems of rheumatology in New Zealand. Comparisons with practice in the UK were unavoidable, and in most respects the standards were similar. This is hardly surprising, since most of the rheumatologists had at some time spent periods of training in Britain. There is a sense of geographical isolation in New Zealand which pervades all aspects of life. Young people in general, and doctors in particular, feel it essential to savour other nations, and many travel abroad to gain experience. The appeal of their beautiful and unspoiled country is such that most itinerant kiwis eventually return, their perspectives enhanced. Ties with the UK remain strong, despite our commitment to Europe. It is to this country that many doctors look when seeking to expand their experience, and to this end schemes such as the Michael Mason and Dorothy Eden fellowships will facilitate the visits of those wishing to pursue rheumatology as a career.

The notion that postgraduate training can be adequate only if partly conducted overseas is in one respect detrimental. Reliance on Britain and elsewhere has resulted in a relatively undeveloped training programme for aspiring rheumatologists. The infrastructure provided by registrars and other junior doctors in rheumatology units is to a large extent lacking in New Zealand. The limited manpower in any one department places constraints on its activities, and research does not therefore figure prominently among the priorities. There are other factors of course, not least of which is the relatively small size population. Few towns are large enough to justify the vital aggregation of rheumatologists necessary for thriving academic units.

There are no more than 3 million inhabitants in New Zealand, and these are outnumbered at least 20 : 1 by sheep. At present the country is served by 21 trained rheumatologists, approximately 1 for every 140 000 of the population. These are concentrated in 8 centres, mainly in the North Island. The small and widely scattered communities of the South Island pose logistical problems for all the medical specialties, not least that of rheumatology. It is common for rheumatologists to travel extensively in order to perform occasional out-patient sessions, and I had the pleasure of flying to Blenheim from time to time to engage in such a clinic.

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The fraternity of rheumatologists is represented by the New Zealand Rheumatism Association, which has approximately 90 members. Unlike the Heberden Society and BARR in the UK, pure rheumatologists are outnumbered by general practitioners, orthopaedic surgeons, and general physicians with an interest. Their meetings have of necessity a much broader appeal than their counterparts in Britain, and the scientific contribution is somewhat diluted as a result. This seems to be a source of contention and some of the rheumatologists I encountered at the annual scientific gathering in Christchurch expressed a wish for the inclusion of more original work in their programme.

The New Zealand equivalent of the Arthritis and Rheumatism Council is the Arthritis and Rheumatism Foundation. This organisation thrives and in 1978 raised more than 3 000 000 NZ dollars during a nationwide ‘telethon’. There is continuing debate about how this money can be best utilised, and at least one imaginative plan has been proposed. This involves the recruitment and funding of rheumatologists to perform an educational role for patients, general practitioners, and other health workers. Whether this will prove viable is yet to be seen. It certainly is in the best tradition of the foundation’s activities, which are in general orientated directly towards improving patient welfare. In contrast to the ARC a relatively small
proportion of its budget is devoted to research, but there are rheumatologists who feel that this aspect requires greater emphasis, particularly if New Zealand is to retain young doctors who wish to train in the specialty.

Wellington is the site of the latest clinical school for undergraduates and its approach to teaching is still evolving. The medical faculty is well endowed with enthusiastic teachers, and rheumatology plays a more important role in the curriculum than in the majority of UK institutions. Dr Burry and his orthopaedic and neurological colleagues have organised a concentrated 4-week course devoted to the locomotor system. It is hardly possible to encompass the whole topic during this period, but it does provide a systematic exposure of all undergraduates to the problems of joint disease. An examination at the end of the course is a serious affair and ensures that classes are well attended. I did sense that students were continually under pressure to attend seminars and lectures in a curriculum which was overgenerous in formal teaching sessions. Medicine was not often taught at the bedside, and the clinical apprenticeship which still forms the basis of teaching in many London hospitals plays little part in the teaching programme.

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As anticipated, the pattern of rheumatic diseases that I encountered was similar to that observed in Britain. The one distinctive feature was the high prevalence of gout among the Maori people and other Pacific Islanders who have settled in New Zealand. It is generally accepted that their susceptibility to hyperuricaemia is to some extent inherited, but the respective roles of nature and nurture are still debated. In particular, the contributions of diet and obesity to their hyperuricaemia are unresolved, and it is of interest that when I embarked on a study of young Maori men in a factory near Wellington, the finding of both hyperuricaemia and obesity was much less than expected. My initial impression may not be substantiated, but it could imply that the latest generation of urban Maoris is more conscious of the health hazards associated with obesity.

There is an increasing awareness of the unique quality of Maori values. Two decades ago the Europeans looked to a future when New Zealand would be represented by a single race, wrought by intermarriage. That view no longer prevails and a burgeoning of Maori culture has followed the recovery of their population which was so sadly depleted in the half-century following European settlement. These warm, spiritual, and friendly people greatly enrich the fabric of New Zealand life, and the social dichotomy and racial tensions which have recently emerged are likely to be constrained by their good sense and pragmatism. New Zealanders frequently refer to their country as 'God's Own.' A land of such unsullied scenic beauty which numbers rugby football among its principal religions is not quite paradise, but is nearer than most.

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Notes

What makes a back ache?

This is the theme of a meeting to be organised by the British Association of Manipulative Medicine on 3-4 April 1981 at the Middlesex Hospital, London. Details from: The Organising Committee, Suite 4, Lister House, 11 Wimpole Street, London W1M 7AB.

Replacement of hip

A symposium on techniques in 'Orthopaedic surgery: selected procedures for total replacement of the hip', at which Sir John Charnley will be guest lecturer, will be held at the Grady Memorial Hospital, Atlanta, Georgia, USA, on 1-3 April 1981. Details from Ronald G Havican, Center for Rehabilitation Medicine, 1441 Clifton Road, N E, Atlanta, Georgia 30322, USA.
Six months in New Zealand.

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doi: 10.1136/ard.40.1.100

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