WORLD WIDE MED

GLOBAL PERSPECTIVES ON MEDICAL PRACTICE

# Internist Abroad: Hospitalist Practice in New Zealand

Dr. Clark Parrish is an internal medicine physician with an outsider's perspective on hospital-based medicine. Although Dr. Parrish currently practices as a partner in the former Madrona Medical Group in Bellingham, Wash., now known as PeaceHealth Medical Group Whatcom Region, he has practiced medicine abroad on two occasions. The first was a 2-month stint at an endoscopy clinic in Gloucester, England, in 1990.

"The thing I liked most about my practice experiences abroad was the opportunity to truly participate in a foreign community as a professional, rather than as a tourist, which allows one to see inside the culture to a much greater degree," he said.

Dr. Parrish graduated from the University of Oklahoma, Oklahoma City, in 1978.

"My first overseas experience was rather serendipitous. I had moved from Portland, Ore., to join a small group of internists in Bellingham, Wash. One of them had spent time in Gloucester, England, learning endoscopic procedures. I was interested in doing the same thing, and so I arranged to spend 2 months working in the endoscopy clinic at the Gloucestershire Royal Hospital," Dr. Parrish recalled.

"It was only while I was there, and reflecting on the experience afterwards, that I appreciated what a wonderful avenue this provided to connect with the people and culture of another land," he said.

Fifteen years later, Dr. Parrish had the opportunity for a sabbatical. "With my experience in England as a motivator, I pursued my position in New Zealand, a place that I had long been interested in visiting," he said. That's how Dr. Parrish came to spend 6 months at the Waikato Regional Hospital in Hamilton, New Zealand, during 2004 and 2005.

"In New Zealand, an internal medicine physician is a hospital-based specialist," Dr. Parrish said. "I spent most of my time supervising the work of the resident physicians—known in New Zealand as registrars—which I enjoyed quite a lot, but sometimes I also felt like a square peg in a round hole."

Although Dr. Parrish continues his practice in Washington, the draw of another opportunity to practice medicine overseas remains.

"I am undecided about practicing overseas again, but would certainly consider it. If so, I might pursue something more Third World, such as the Himalaya region," he said.

***What are some advantages and disadvantages to hospital-based medical practice as you experienced it in New Zealand, compared with the United States?***

The main disadvantages of the U.S. system in relation to those in England and New Zealand that I observed have to do with how wasteful and excessive our system is, in relative terms. I don't think that American society is getting good value for the money we spend on medical care.

***Could you elaborate a bit about what you enjoyed most and what was unique about working as a hospital-based specialist in New Zealand?***

First of all, working as a hospital-based "specialist physician" was quite different from my role as an office-based primary care internist here at home. In New Zealand, as in England, primary care is provided by general practitioners while internists act as consultants almost exclusively, which was a change from my previous experience as an internist in the United States. My most important responsibility was supervising the work of a team of "junior doctors," as most of the work on the medical wards is done by the physicians in training. The house staff hailed from all over the world, including Polynesia, Malaysia, the United Kingdom, India, Pakistan, Bangladesh, and South Africa. This was the most rewarding part of the job for me.

In addition, my team took care of an impressive variety of clinical cases, many of which I have never seen in private practice. Some examples included acute falciparum malaria in a university professor who was doing linguistic research in Vanuatu, and a case of acute meningococcal sepsis. New Zealand unfortunately continues to struggle with an ongoing epidemic of meningococcal disease. I had the luxury of plenty of time to spend in the library researching these interesting cases and bringing reading material for my house staff.

Also, once a week I traveled 2 hours south of Hamilton to the small town of Taumaranui to supervise the work of the "medical officers" who staffed the small hospital there and to see patients in a medical clinic, who had been sent by their local general practitioners for consultation.

***In your experience, what did the hospital where you worked do better than U.S. hospitals? What could a U.S. hospital learn from a New Zealand hospital?***

I wouldn't say that the hospital itself did anything particularly better than U.S. hospitals, but rather that the New Zealand health care system, coupled with different societal expectations, did a much better job of being less wasteful of resources than the American system. Of course, this efficiency is accomplished with many trade-offs, many of which would likely be unacceptable to Americans. For example, patient beds were in large open wards, with only curtains for privacy, and no personal phones, TVs, etc. And patients experience interminable waits for many services, such as low-priority MRI scans. The New Zealand health care system also faces the challenge of how to incentivize physicians to optimize productivity in the absence of profit motives. As in England, New Zealand is moving to a two-tier public/private system in an effort to access the best of both worlds. However, medicine in New Zealand is anything but backwards, and I was impressed by the high caliber of care provided with limited resources.

***What were some similarities and differences between your experience at the clinic in England and the hospital in New Zealand, in addition to the differences in technology that occurred between 1990 and 2005?***

The two experiences had much more in common than any differences, as New Zealand's health care system is patterned after the health care system in the United Kingdom. One interesting difference over the 15 years, reflecting a worldwide change, was the prevalence of obesity-related illness, especially diabetes and the attendant complications, that I witnessed in New Zealand. This was a bit of a disappointment, as I had envisioned a vigorous population, enjoying the myriad opportunities for outdoor recreation.

COURTESY DR. CLARK PARRISH

**Dr. Clark Parrish spent 6 months in New Zealand supervising an international group of hospital physicians in training.**

***What advice would you give to other doctors who are thinking of volunteering overseas but are unsure of how it may affect their personal and professional lives?***

Just do it! Practicing medicine overseas, in my opinion, honestly is worth almost whatever it takes to make it happen. I estimated that my 2 months in England cost me around $30,000 (in 1990 dollars), including lost income and expenses related to hiring a locum to cover my practice while I was away. But being part of a large medical group made the longer New Zealand sabbatical more feasible and affordable. The experience can be so personally and professionally enriching, both for the physician and maybe even more so for family that tags along for the ride. ■

*—Interview by Heidi Splete, Senior Writer*

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*U.S.-trained internists who have practiced abroad will receive a $100 stipend for contributing to this column. For details, visit www.wordwidemed.org or send an e-mail to imnews@elsevier.com.*

# WHO Recommends Steps to Reduce Global Health Inequities

BY JONATHAN GARDNER

*London Bureau*

Improving living conditions, reducing income disparities, and measuring the effects of specific steps to reduce inequities in health care all are necessary to eliminate the effects that deprivation has on global public health, the World Health Organization said in a report.

The WHO report on social determinants of health called for better education, particularly in early childhood; improvements in workplace conditions and full and fair employment; urban and rural development that increases affordable housing and improves sanitation; development of social programs, including health care programs; and reduction in disparities in wealth and power.

Measurement of both the problems and how well any solutions worked is necessary to reduce the disparities and would include goal setting on health equity, using health-equity surveillance systems in member states and impact-assessment tools, as well as convening a global meeting periodically to assess progress.

Wealth and economic development are not solutions, WHO officials said, pointing to sharp disparities in life expectancy in a relatively high-income city like Glasgow, Scotland, even as relatively low-income countries like Sri Lanka have narrowed health inequities.

"Central to the commission's recommendations is creating the conditions for people to be empowered, to have freedom to lead flourishing lives," said Sir Michael Marmot, a professor of epidemiology and public health at University College London, and chair of the WHO Commission on Social Determinants of Health, which prepared the report.

"Nowhere is lack of empowerment more obvious than in the plight of women in many parts of the world," Dr. Marmot said in a written statement. "Health suffers as a result. Following our recommendations would dramatically improve the health and life chances of billions of people." ■