

THE
MEDICINE STORIES
PROJECT



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About the Medicines Stories Project

Hi everyone – and welcome to the Medicine Stories Project. We were a small website established in 2015 and then finally put to rest in 2020. We were new but we wanted to do something that we hoped was very simple – collect the stories of doctors. We began as a collaboration between Ko Awatea and the ASMS and we think that medicine, at least in part, is a storytelling profession. We wanted to celebrate that. We believe that sometimes narrative and the subjective can be just as good at pointing towards illness and what to do about it as the objective.

You all know that what we know about the body, its illnesses and the treatments for these illnesses is constantly evolving. And the scientific method is an amazing tool in this regard – so good that in many ways the language of science has become the language of medicine.

But medicine is an old art form as well. And at the heart of its practice is the consultation. This involves a patient telling a doctor a story. Bodies have a plot, as do illnesses and treatments and doctors. Often untangling and interpreting these plots can shed light on a person's situation, as well as a pathway forward in any treatment they might need.

Listening well is a way of caring for a patient and for ourselves, i.e. it is a medicine in itself. But there seem to be so many pressures at times that interfere with our ability to do this simple thing well.

The Medicine Stories Project wanted to share what we learn when clinicians do listen well or reflect or wonder. We wanted to collect and distribute the stories of doctors and their patients. We hoped that they might become a tool for doctors to gain experience from each other, and a way of standing back and seeing ourselves as a profession. We thought the site might also be a place for us to download our joys and sorrows and frustrations and angsts – as well as the sense of wonder the job can bring.

It seems that there are few places where we can talk about our subjective experiences in medicine. The language to do so somehow seems a casualty of learning to speak in a way that, at its best, does not value the local and, at its worst, pretends an objectivity it does not really possess. The Medicine Stories Project was a small but brave attempt to offer a counterpoint to this.

So we invited colleagues in the health sector to write down some of their stories of medicine and send them to us at The Medicine Stories Project. They might come in many forms – as memoir, song, poetry, drama or fiction. They might be a letter or a scrap of recollection. They might be stories that wonder at the body, or the individual patient and personality, and the way these interact within a community or with the sensibility of the doctors who are part of them. If there was a story, or simply an observation, and you were not afraid to write it down, we were asking you to send it in.

It didn't matter what speciality or style of medicine you practiced, or whether you were a medical student or retired from the profession. If you have been a doctor, or are on the path to becoming one, then we loved to hear from you.

We acknowledged each story and archived them all. We believe that in their range of style and topic they might build a picture of our profession that is accurate in its accumulation. Throughout the project we didn't have many resources to put towards the project so we were not always able to give detailed feedback on every piece submitted. We would have liked to anthologise a selection of pieces on the site that show literary quality or hint at underlying currents within our profession or that simply could not be put down.

We think that doctors will always deserve an outlet for what we see and hear. No matter how unhappy or unfamiliar you feel writing things down, we each have stories that range from the tender and poignant to the laugh-out-loud funny. We welcomed them all. We encouraged you to pick up a pen and 'why not say what happened.'

Our best wishes,

The Medicine Stories Project Team

The Project Team



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Memoirs

Glen Colquhoun

Sinead Donnelly

David Galler

Trevor Lloyd

Alastair MacDonald

Jill McIlraith

Jane Miller

Paul Reeve

Anja Werno

Glenn Colquhoun

Middlemore is My Hospital

By Glenn Colquhoun -
February 16, 2016



This is an address I gave at the opening of Ko Awatea in 2011. In some ways this is where The Medicine Stories Project started. Having put my thoughts down here I found it hard to shut up and walk away from them. Reading through it again I realised it will go up on the site the same week my niece will start her nursing training at the Manukau Institute of Technology. She has been working as a volunteer for a couple of years now at Kidz First. It seems Middlemore is still the family hospital.

Ko Middlemore te hōhipera

Middlemore is my hospital

My grandmother began in that lane that runs from the top of Miles Avenue through to Wallace Road in Papatoetoe, though there were traces of her from the time you entered the street at the top of the hill where it joins into Fairview Road. There was a zooming down the gully on my bike, a short coast halfway up the other side and then the long narrow lane. On one side loomed a large wooden villa, a home for old nuns. On the other side, over a green corrugated iron fence was Nana's house. The lane and the green and the corrugated iron all seem part of her now, a memorial anatomy.

Nana was straight-backed. If you lived in Papatoetoe long enough you would have known her as the old woman who rode her bike down Curruth Road long after everyone stopped riding bikes. She would have been in her late sixties, and on the way to visit us in Puhinui Road. She sewed our clothes and knitted for us and had a way of clearing her throat that signaled displeasure. We were Seventh-Day-Adventists but she let us dip our biscuits in her tea out of sight of my parents and sometimes encouraged us to drink it. For all her sense of propriety, she retained a sensible rebellion. Her hair was tightly curled and unruly. It made her handsome rather than beautiful.

She died down the road, here in Middlemore Hospital. I was twenty-three at the time, long before I considered medicine as a career. I remember standing over her bed in the coronary care unit. She was pale and small and tired. I was comforted by the whiteness of her sheets and the way her bed held her neat in its hand, and by the steadiness of the cardiac monitor pulsing above her bed. I had no idea what its lines meant then, but they moved and glowed as if evidence of life itself. Hours after being reassured, she ruptured her intra-ventricular septum and died. My mother told me her heart had burst and I have always preferred that explanation. Her death is associated in my mind with the polished linoleum of the corridors that criss-crossed the hospital then, and by the funereal plywood panels that reached up the walls, as though the whole building itself was a casket. She is a spirit here now. I like to think of her riding her bike up and down the corridors of Middlemore, cutting between people or through them, her curls flying out behind her like the tail of a comet.

Pop, her husband, died in Middlemore as well, in the same coronary care unit thirteen years earlier. That last night I spoke to her, Nana pointed out the bed he had been in. He was a builder and painter and more than a few houses you pass in Papatoetoe on the way to the hospital were built by him or by my father a generation later. I grew up having them recited to me whenever we drove past: Kolmar Rd, Great South Rd, Omagh Ave, Tui Rd, Shirley Rd, Hillcrest Rd. He spent hours telling me as a child of his exploits in World War II. He had been sent to blow up a bridge that the German army was advancing over. After setting the charge he waited out of sight. The soldiers tested the bridge by walking the women and children of a local village across it. Pop waited until they had passed and the heavy artillery was mid-river, before bringing the whole thing down. Pursued by the remnants of the force, he leapt into the river and swam, bullets piercing the water around him. He stayed underwater until the Germans stopped searching for him, breathing through a broken reed. Really he had spent the war building a factory for mining sulphur on White Island, just off the Bay of Plenty. If he went to hell for lying he would at least be used to the smell.

A hospital is a city between the living and the dead. When Odysseus visits the underworld he digs a pit in the soil with his sword, out of which the dead stream upwards. When Māui attempts to win eternal life he enters the vagina of Hine-nui-te-pō, the great goddess of death, in order to reverse the process of birth. It is here that hospitals belong, deep inside all pits and tunnels. Within them we attempt similar feats of defiance and passage. And inside them we have the same commerce with the dead. Maybe that is why they are so full of corridors. Lives begin and end here, or perhaps they simply change phase. Who can say? Either way, hospitals are not only holey, they are holy. I'm sure there are those who have called Middlemore a great vagina in the past. I am less sure they have meant to invoke the same mythologies.

My father did not die in Middlemore, but he did go mad here. In Ward 22 to be exact. He was living around the corner at the time and had suffered from Parkinson's disease for twenty-five years. His body unravelled in that way bodies do at times, the pillars toppling into each other like Samson bringing down the temple upon itself. The end began simply enough with a urinary tract infection which led to what we thought was a delirium. He was admitted to Ward 22 but he did not get better. The infection cleared but not his mind and he was diagnosed with Lewy-body dementia. Looking back, the madness had been approaching steadily but surely for a long time, but we had tried to shake it off. We knew he was in trouble when he rang my mother shortly after his admission, using a phone box just down the road. He said he had been discharged and asked her to pick him up. She rang the ward, who said he was tucked up in bed – until they checked. He lived out the next few years in a dementia unit in Parkhaven, not far away. We had picnics there every couple of months with his mad friends, who in a strange way entered the family. Medicine confers on those who practise it the knowledge of how their loved ones will die. We see the weapons arrayed and wonder at times which will be turned on us. It allows us warm deaths in a way, the feeling of being slaughtered by a friend perhaps, knowing exactly what is to come once they slip out of the shadows.

For the first two years of my clinical training I spent as many runs as possible at Middlemore. I learnt to draw blood here. Our lecturers advised us to practise on each other. My lab partner and I did this once, looked each other in the eye and knew that was never going to happen again. From that point on I joined the phlebotomist on her rounds and practised on patients. That was what they were here for after all. It was a good way to learn the dark arts, and a useful guide to every nook and cranny of the hospital. Veins and corridors have a lot in common, a random evolution.

I learnt about the power of compassion here as well. It arrived in the person of Professor Sir John Scott, who looked after me on my first medical run. He seemed to practise medicine by magic. It's true his knowledge was encyclopaedic but he had something different. Perhaps it was the practised acquisition of thousands of experiences in medicine that made his manner effortless, but I suspect there was more to it than that. He had a way of being with people that attracted their pains to the surface, where he would nod and smile with sad eyes. When he put his hands on people he did not so much take some secret knowledge from this, but infused some sort of medicine into them and calmed them. He had a way of talking and touching that was healing in itself. Years later that image haunts me when I feel the same sense of frisson with a patient. It leaves me pondering exactly what does happen between doctors and patients. What passes between us when we are with each other that we do not see, but sense sometimes like a shiver?

In 1995 I lived two months of my life in the department of obstetrics and gynaecology at Middlemore Hospital. I was sitting my final exams in medicine and its library was one of those out-of-the-way places I had found to hide and get things done. I studied with my friend, Josh Tutone. We made up notes and tested each other and sweated through old papers to get ourselves in shape. Later we would drive down to the shops just over the bridge on Massey Road and eat Burger King or KFC to return to the shapes we began with in the first place. We were South Aucklanders after all, and it was our cuisine. There is a special love reserved for those who have been comrades through such endeavours. When I think of the causes of anaemia or of peri-natal bleeding or of vaginal discharge I think of that room

and of Josh now and wonder if he thinks of me. We might test each other still, counting off answers on our fingers and sweating over the ones which always stubbornly refuse to arrive.

In our family photo album there is a picture of my youngest sister as a baby in an incubator. She is swaddled and asleep and looks like all well babies born at term, snub-nosed and condescending. She was born on a Sunday at half past ten in the morning, the fourth child in the family, and she gave my mother little trouble. The labour was over and done within a morning, only a little longer than it would take to get us all off to school on any given day for the next fifteen years. Faced with a choice between the two options again, I feel my mother would choose the labour most days. Her birth took place in this hospital forty years ago, although my sister might say thirty-nine. Elsie Olive Murray, Nana's mother and my daughter's namesake, died here in 1966 after a stroke. Her husband James did as well, six years earlier, three weeks after a heart attack and the day before he was to be discharged. Most of my nieces and nephews have taken their turn waiting in the emergency department here to deal with the assorted fevers, lacerations and broken bones of their childhood. I have even had my car stolen from the hospital carpark, a rite of passage for all who belong to this community. All in all, five generations of my family have been born, treated, trained, and died in Middlemore. It is our family hospital if such a thing exists, and I very much hope it does.

The '60's and '70's were a wonderful time to be part of South Auckland. Māori and Pacific Island families were flooding into the area. Papatoetoe slowly became a smaller and smaller white island surrounded by the great brown suburbs of Ōtāhuhu, Ōtara, Manurewa and Māngere. For all that, it was the potato salad that undid me. I first ate it at the opening of the Ōtara Seventh-Day-Adventist church my father built. My family were seated at an impossibly long table sagging with all sorts of new and wonderful food and right in front of me was a glistening mound of mayonnaise decked on as small a garnish of lettuce as possible, a flimsy green tutu on a great white elephant. It reminded me of a freshly draped abdomen the moment before incision. Inside it dripped with blood. Beetroot and potato and mayonnaise sat on my plate like a sexy autopsy. Here was the perfect blend of Palagi and Polynesian in something as mundane as potato salad. The possibilities we offered each other seemed endless. South Auckland was sensual and funny and excessive. This was its food and I was its child.

During those years, many Palagi in Papatoetoe fled to Howick or the Gold Coast, but my family stayed and fell in love. Six of my mother's eight grandchildren are Samoan or Māori. All are Pākehā or Palagi as well. We were blended. It was an experience of being Pākehā that has dominated my medicine and my writing since. When I started my training in Middlemore there was no other place I wanted to be. There were few architectures in my city then which combined brown and white so markedly, skinny pinched old Pākehā on their thin hospital gurneys, a single relative sitting quietly beside them, and great Polynesian bodies welling over the sides of their beds like well-browned loaves of bread while a scrum of kids dismantled the waiting room around them. We bled and laughed and died here together in a shitty old building next to a golf course distressingly green and King's bloody College – as if God himself was taking the piss. This is my home. An Air New Zealand 747 on final approach over Manukau City Centre is my mountain, the great southern motorway is my river, the sewage ponds glistening under Māngere mountain in a westerly are my moana and

Middlemore is my hospital. These landscapes are with me everywhere I go. I am creamy-brown.

South Auckland is the richest melting pot of peoples that we have in our country and it is extraordinarily valuable to us because of that. Older, more established cultures bend and change there as new ones impact upon them and change themselves in the process. It is the human equivalent of a fault line: Europe, the Pacific, Asia and even Africa now grind together, buckling and twisting a cultural landscape complete with folded hills, soaring mountains and sharp escarpments. For so long it seemed to be a place that was shunned, however – perhaps for that very reason. It was ragged and dangerous and poor. Mainly it was misunderstood. For me one of the surest paths to understanding in that maelstrom of meeting has been in talking to each other. When we went to each other's places and listened to each other's stories we started to recognise the same themes: love, hope, sorrow, longing and decision. There were few architectures of our meeting in the South Auckland of my youth. Playgrounds, schools, the odd shopping centre, swimming pool or church but none particularly shaped like those of us being bent or reflecting that bending. It was a city of churches and KFC with the blunt black pencil of the southern motorway ruled through it. The airport was distinctive but scrubbed clear of too much brown. Visitors were quickly escorted out of the south to our harbours or volcanoes and kept away from the generative forces that gave rise to equally powerful shapings.

Middlemore was our architecture and did not run in the face of what seemed ugly on the surface. It mixed our bloods literally, cleaning up after us on Friday and Saturday nights, scrubbing our vomit and piss and shit off its floors. We howled here with Polynesian abandon and we sniffed parsimoniously into our Victorian hankies, stiff upper lips quivering until we eventually understood the grief behind both ways. It was a dump but so was the whole suburb. It was our dump though, and its crazy, nonsensical corridors and add-ons and add-ons to add-ons seemed to reflect the conflicts and resolutions taking place all over our city. Slowly, extraordinarily slowly it rose out of the impact of our various cultures and stories to reflect and protect us like some strange transformer, gleaming at full stretch out of a rusted old car body beside the railway tracks, our very own Optimus Prime. Those who couldn't abide who we were left, and those who stayed grew to love us until they were part of us as well.

Architectures are important because they house us. Five generations of my family have bled in one way or another in Middlemore. It has rubbed off on us and we have rubbed off on it. It is a marae of sorts, our ghosts lie here and inform it, along with the ghosts of those who have shared this piece of dirt with us. I am spooky enough to believe in ghosts after twenty years of medicine and I can't help thinking that all the dead of Middlemore somehow give it lustre and dimension and a powerfully fecund doubt. But architectures are also important because they physically represent or point towards our states of mind, reflecting what we are thinking and helping to stake that territory. They provide a fulcrum to lever ourselves further into the great conversations of identity. Middlemore is an architecture of the South Auckland soul. It is shaped by us but also shapes us. There is a Middlemore of wood and steel but there is also a Middlemore of the imagination. This hospital has a place in our cultural lives. We all know it and our stories feature in it. To me it represents humanity in the face of difference. It is an institution that has thrown its lot in with the community it is part of. It has been poor when they have been poor, dirty when they have been dirty, as irrational and tangential and infuriating as all of us. And it has become ours. Above all else it

has stayed and it has endured and it has become kind when it could have despaired. It has seen that we are funny and beautiful and generous and proud.

Human beings live in communities, as do their illnesses. Because of this, hospitals in the fullest sense belong in and to those communities. One entity establishes an equilibrium with the other. It is supposed to be polite, a gentleman's agreement. But Middlemore never had a say in any of this. The community it served refused to draw any boundaries between their lives and its doors. They opened the gates and came right in as if they owned the place. The hospital flooded with a sea of humanity because in an old-fashioned way that humanity expected their hospital would be there to care for them. They did not suffer from the mad sophistication medicine sometimes fractures into, which stammers care into bundles and denies its ability to just shut up and kiss us. The irony is that what Middlemore found under that sea preserved its soul in important ways. Perhaps it was my Pop showing them how to breathe underwater. I have lost count of the times that patients save their doctors' lives and see no reason why the same should not be true of a hospital as well. It would be a perilous thing for Middlemore to forget the debt it owes to its community, no matter how it might whinge about late presentations and overcrowding and seeing your GP first and decile levels. How often in life is it the sea that saves us from drowning?

Human beings also exist in relation to big questions. Who am I? What is of value? How should I act? Perhaps most compelling of all, am I important? In general practice so often the management of someone's illness rapidly defaults to these questions. Human beings are spiritual and this spirituality is the most powerful medicine we possess. Where it is present no illness can erode, and where it is absent no physiology, however pristine, brings a sense of ease. At the end of the day biology turns into chemistry and chemistry turns into physics and physics turns into maths. In a similar way there is an open border between medicine and spirituality and for me 'spirituality' is simply another way of saying 'our stories'. Our stories tell us who we are and how to act. They tell us what we are worth. They also move with time, providing points of entry and exit into our lives. Interacting with someone's story is almost always more effective than fooling around with their medications. As a doctor I need to know about the pharmacology of SSRI's but I use Dickens and Woolf and my father and Nana much more often.

And so I come to my point. In a place where Middlemore considers its links to the cultural life of the community it is part of, I want to ask it to especially consider the spiritual lives of the people it serves. All medicine finally comes to this. Our stories are an intrinsic part of our well-being, and so please let Middlemore tell our stories, stories without fear or favour, stories told in music, in art and in literature, ones that show our beauty and our doubt. Let it reflect who we are and in doing so point the way to our becoming. Let it display them so that we can see what ails and what heals and so that we can see ourselves and compare.

Churches and universities have long been institutional patrons of the arts, but the stories that take place in hospitals at least match those that take place in these institutions, and often far outstrip them. Lives begin and end there. Why shouldn't hospitals foster programmes in the arts? People look for answers to the big questions here, as much, if not more, than anywhere else. It is good medicine to preserve our anecdotes and to say that others have searched and search still to understand our fragile, blessed humanity, that here our vernacular exists, capable in the sum of its disparate parts of bringing succor, enlightenment, camaraderie and insight. Our spirituality is so awfully wounded in the

twenty-first century West and our collective stories are still the best source of spirituality I know. Let there be somewhere in the hospital where the randomised controlled trial is balanced at least with the ruthless, intuitive, sensual subjective.

To conclude and to underscore that process, let me leave you with my own small South Auckland story composed in streets not far away a long time ago. My warm congratulations to you all on the opening of Ko Awatea. It is a brave and forward-thinking resource to build in a hospital, a narrow reed perhaps to breathe through as the bullets zip. Thank-you for your patience. Thank-you for your colour and for your noise. Thank-you always for your myriad ways of being human. I have never ceased to be your son.

Bred in South Auckland

I drive a car that is falling apart.

There is bog in the body.

There is rust in the doors.

Occasionally it does not have a warrant.

Sometimes I sleep in large rooms full of people.

I eat too much fried bread.

I am late to meetings.

I go to housie.

My nose is flat.

I say Raw-tore-loo-uh.

Some people think I am a bloody Māori.

I have been to university.

I have a student loan.

I photocopy my tax returns.

Most mornings I read the newspaper.

I make lists of things I have to do and like to cross them off.

I cut apples into quarters before I eat them,

Then I cut the pips out.

I put my name on things.

I listen to talkback radio.

Some people think I am a typical Pākehā.

Last week I drove through a red light,

I did not slow down at a compulsory stop,

I changed lanes on the motorway and did not use my indicator.

When I was a boy I went to see Enter the Dragon,

I took one lesson in kung fu.

My parents made me do my homework.

My brother gave me Chinese burns.

I like beef and pork-flavoured two-minute noodles.

I light incense when the house smells.

Once I dug a garden.

Some people think I am a blasted Asian.

When I was a boy I learnt to swear in Samoan,

I went to school in Māngere,

I played rugby in bare feet.

Sometimes I shop at the Ōtara markets.

My family come from overseas.

I used to work in a factory.

Once I helped to cook an umu.

When it is summer I wear a lavalava.

I drink pineapple juice.

I like to eat corned beef.

Some people think I must be a flaming coconut.

I think I am the luckiest mongrel I know.

Late Love

By Glenn Colquhoun -
June 12, 2017



Glenn Colquhoun talks to Kathryn Ryan on Radio New Zealand about “Late Love”, his recent book about the overlap in his life between poetry and medicine as well as his work as a GP working with young people in Horowhenua.

Listen to the full interview [here](#), courtesy of Radio NZ.

Sinead Donnelly

To Write of Martin B

By Sinead Donnelly -
February 14, 2016



I believe in the fullness of an encounter. There are so many in palliative medicine. I believe that by paying careful attention, moments full of infinity happen. When I am not fully present, these moments pass me by ... forever.

To Write of Martin B

Nineteen years. His age is important.

He had a teddy bear beside him in the hospital bed.

He was the centre of their attention. They could not attend to each other.

The father towers. The mother is small and quiet.

She left the home. He reared the two boys.

Martin wants to stay with his mother as his illness progresses. Maybe it is a practical decision. Maybe it is more.

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On his last admission we were invited but not welcome.

Our presence was not benign – the sarcoma likewise.

It spread from the left thigh to his lungs.

That day he looked great – a Greek greatness.

Pale, pale with dark rimmed eyes as an actor would be made up to look sick.

But this was real. Or was it?

His recurrent nightmare was of his coffin, about to be opened for him to see himself. He would wake up before the lid was removed.

We were told this by the oncologist who fights death valiantly for her patients. In palliative medicine we do not resist death. We respond to its proximity and wait.

Martin told me he did not want to talk about the nightmare. He talks to his father and brother about it.

On Tuesday he greeted me with energy and enthusiasm. He looked at his mother seated beside him repeatedly asking 'Are you alright? I will keep asking are you alright.'

For the first time he seemed orientated firmly and boldly towards another.

Somehow he was growing before my eyes. I thought: *Here is a man coming into being.* I sensed the hospital bed getting bigger and higher, as though rising before me. His mother and I seemed smaller – an Alice in Wonderland effect. I was curious and pleased.

That was the second to last day before my holidays.

I did not see Martin again.

The Afternoon Before Christmas 2009

By Sinead Donnelly -
February 16, 2016



I wrote this piece on Christmas Eve, the day I met this patient. It is consoling to read again every year, as Christmas can be lonely as an immigrant to New Zealand.

The Afternoon Before Christmas 2009

Christmas Eve on the surgical ward. One more referral seems a bit too much for me.

She was ninety eight. Being admitted to hospital at 98 years – why?

She is from Turkey with an irreducible hernia. They tried to manually relieve it using fentanyl and midazolam intravenously. She sits sideways across the bed, her swollen limbs dangling over the edge. Her curved body is propped up by many pillows, her white cotton scarf knotted turban-like at the front on her forehead. She is dozing. Her daughter Nareema translated in a beautiful accent as I asked in plain English about her pain and nausea; so plain a language in comparison.

Another daughter arrived in a rush of brown colour and tension. I greeted her and the tall young man ahead of her.

“You need not greet him, my son is autistic, he will get upset.” She rubbed the tall man’s back kindly and constantly as he looked away, his thumb in his mouth ...

I tried to explain palliative care to both daughters this time. “The surgeons think operating would be unwise.”

“Too old you mean, her age, of course ...”

“No I’m not saying it is because of your mother’s age ... the anaesthetic ... she might not survive.”

“Well you mean her quality of life ... she has no quality of life.”

“No, I am not commenting on the value of your mother’s quality of life ... she might not survive the procedure.”

As I was preparing to leave I knelt down in front of her, held her hand and caught her attention. She looked at me, smiled broadly. I complimented her on the turbaned scarf, knotted skilfully.

“When you compliment something she will offer it to you,” her daughter explained.

So I complimented her on her smile; the magnificent wrinkled ninety eight years-of-life smile. She gave it again. The stressed daughter in brown with the tall autistic son in black softened, eagerly sitting close to her mother and translating.

In one look, one smile, I was enriched. If I had not knelt before this woman, I would have missed those beautiful life-long eyes. I would have missed Christmas.

Once Upon A Time ... I Knew All This!

By Sinead Donnelly -
February 16, 2016



This is part of a longer essay recording my year of transition from palliative medicine to acute medicine. I write to console myself and to capture the extraordinary in the ordinary.

Once Upon A Time ... I Knew All This!

I moved from palliative medicine to acute medicine in July 2013, having practiced palliative medicine for 23 years in Cleveland, Glasgow, Dublin and Wellington. I thought the anxiety and fear would kill me! It was equivalent to leaping off a bridge into cold rough salty sea water in the Southern Hemisphere winter every day. Clearly I wanted to give myself another challenge! Did I survive? Do I have any regrets?

Initially on Saturday or Sunday on call for the weekend for acute medicine I would hold my breath as diagnoses were rattled off. I used to know all this ... once upon a time. How was I to navigate my way, knowing that I was once a registrar on top of my game in general medicine in tertiary referral and national referral hospitals? Once is a long time ago. Sepsis, fluids, CPAP, BiPAP, troponins, metoprolol for atrial fibrillation, anticoagulation for atrial fibrillation, thrombolysis for stroke, even D-dimers for PE ... so much has changed. And what has happened to digoxin? How do I use BiPAP, CPAP? What do the numbers on the side of the machine mean?

Fortunately for me there is much palliative medicine in acute medicine. Such well known practice was like a calm place for me to glide my boat gently into the harbour where a person was dying. That world I knew well. It was a delight and ease for me to bring a registrar and house surgeon, junior doctors, young doctors along in a well-appointed boat. I sailed easily. It was very soon evident to me that palliative medicine applies directly to at least one third of patients admitted acutely under medicine.

Let me tell you a story where acute medicine and palliative medicine intertwined.

Mr W (89) came to the Emergency Department during the night. The registrar summarised the patient's story of shortness of breath. I met Mr W on Saturday morning with Ella, the registrar for that day. He was returning from the toilet, sitting now on the side of the bed and breathless. I was unsure how different this was from the time of his admission six hours before. I thought he had heart failure. We asked the nurse to give him frusemide. I thought the tracing of his heart (ECG) suggested ongoing damage to his heart. We continued seeing other new patients.

About an hour later, an alarm bell rang in the Medical Assessment Unit – Bed 23 – Mr W's bed. The nurse was there. He had just died. I decided immediately that CPR was not appropriate. Ella consoled the nurse, who was upset that she had left him just before he died. I phoned his daughter as the identified contact person. She cried, clearly surprised and distressed. She said her mother was just then getting his clothes ready, preparing for him to come home that day.

They arrived about two hours later. His wife was in a wheelchair, crying. She was afraid to go into the room where he lay. I encouraged them all to enter the room. Mrs W lifted herself out of the wheelchair by his bedside, leaning over him, almost lying on him, weeping, hugging him, talking to him. My heart broke at the image of this small lady leaning over this man, her husband of 65 years.

I could not understand why I was so upset after 22 years in palliative medicine. I think it is because in acute medicine, unlike palliative medicine, you are so close to the front line; because in acute medicine you do not have your palliative medicine armour on. The chaos and uncertainty, the surprise factor of acute medicine, render me exposed and vulnerable. "Palliative" comes from the word "pallium" – to cloak or shield – generally accepted as the professionals cloaking the sick person in care. But now I know "pallium" used to shield me.

The poignancy intensified. I sent them a card offering my condolences. Mrs W responded, phoning me to request a meeting. "Oh dear," I wondered ... A week later we sat again in the same room where she had hugged her dead husband. Mrs W said "The nurse phoned me that morning, said S wanted to speak to me." As the nurse brought the phone to his bedside, "the battery died." So they never spoke. She presumed he wanted to tell her to bring in his clothes; that he was going home. So she started to get his clothes ready. Now she wonders if he wanted to say he loved her. "Is that what he wanted to say ...?"

Mrs W thanked me. They all thanked me. My heart was breaking. Acute medicine – no place for the faint hearted.

David Galler

Extract from “Things That Matter”, by David Galler

By David Galler -
March 15, 2017



Extract from *Things That Matter*, by David Galler (pages 130–136)

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Our mystery man was still on a ventilator, I hoped asleep as a result of the sedation we were giving him rather than unconscious due to a massive head injury. What I did know was that he was far too unstable for us to move him to be scanned in order to find out one way or the other. As it was, we were still only partway through our guideline for the assessment and management of severe trauma and still stuck at C!

Just keeping him alive had been our focus. He had multiple lines in now—big intravenous catheters in his right and left internal jugular veins for fluids, drugs and dialysis; an arterial line in the radial artery of his wrist; the large bore sheath in the right femoral artery through which Rowshan had so skilfully directed his catheters; a nasogastric tube to drain his stomach; his breathing tube of course attached to a \$65,000 ventilator; and a urinary catheter, its drainage bag sadly empty of urine.

Although some of his bloods tests were better, because his kidneys had failed his blood desperately needed cleaning up. Gingerly, we got him onto dialysis with small boluses of adrenaline to keep his blood pressure up.

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It had been a weird evening and I was sure something unusual and mysterious was afoot. I was exhausted but energised and strangely elated too! I walked around the ICU, checked on the other patients and then took a stroll outside. It was a beautiful night. In days past, I would have jumped the fence and gone for a swim in the hospital pool, but that was now long gone. I was hungry but all that was available was crap from an array of vending machines better trained to take your money than give you sustenance. A comfortable chair and my feet up on a verandah rail looking out across the night sky would have done but there was nowhere for that. Sitting in an office looking out the window wasn't even possible because there were no offices with windows available to me. How weird, I thought, this place is supposed to make people better but it is so awful on so many counts.

There was one saving grace though: hospitals at night, stranger places than they are during the day, are ripe for the imagination to flourish. Like the southern motorway at the same dead time of night, they too have one long, empty corridor after another. The only signs of life are an occasional cleaner in a cowboy hat riding a big floor polisher, our equivalent of a growling roadworking machine lit up like a Christmas tree. Like the odd car, an occasional house surgeon will run a red between well-lit pods that could be gas stations but instead are the nursing stations on the wards. I want to breathalyse them all.

'Life can only be understood backwards, but it must be lived forwards,' said the great Danish philosopher Søren Kierkegaard. Ghosts and memories flood back to you in those dark hours before the dawn. Did Mama, the thirteen-year-old girl from Aitutaki, really need to die? Couldn't we have done more? Dr Ken Mayo, his photo on the wall at the entrance to the radiology department, dead at fifty. His weathered face above his Viyella shirt and neatly knotted tie etched in my brain forever. I never want to end like that, all alone, dropping dead at work. I used to worry that one day I too would be remembered by a photo on a wall in the ICU but as time has passed so too has my anxiety about ending that way, certainly at that age.

I carried on past the entrance to the closed cafeteria and remembered the time I organised a concert by Tim Finn, who played to a crowd of kids and adults, all with burn injuries. The venue was grungy, the ceiling suitably low and pockmarked, much like the one at Ronnie Scott's club in Soho. It was 25 June, Tim's birthday and, at the end, all the patients and staff returned the favour and sang him a rousing version of 'Happy Birthday'. He said it was the best present he'd ever had, and both he and I almost cried.

Down towards the coronary care unit I drifted. This place was a good run from the ICU on the first floor of the Galbraith block, opposite the Middlemore railway station. I've lost count of the number of long sprints I've done from one end of the hospital to the other to rescue patients from their hearts stopping prematurely, at the same time always anxious they might restart long after damage to the brain is certain. Arriving there, gasping, I would wonder whether I was next in line for a coronary. Catching my breath, I would follow the ACLS guidelines to shock and thump that dumb organ back into sinus rhythm.

At the end of each case, no matter the result, we always had an informal debrief over a cup of tea and a gingernut—biscuits that were always present in the jar at the nurses' station. Looking back, these were special times: our performance was reviewed, new relationships were formed, and old ones reaffirmed.

As I wandered, I remembered the day in the early 1990s when—after a long and unsuccessful attempt to resuscitate a youngish man—we found the cookie jar empty and the

tea no longer available. There was no debrief that day and we all trudged disconsolate back to our home wards. Soon after, the crackers, cheese and jam disappeared from the theatre tearoom, and with that stopped the unspoken, easy and relaxed conviviality that resulted from those of us attracted to it.

A face seen is a problem solved but there seemed little time or place for that kind of simple interaction between members of the specialist staff so soon after the mother of all budgets. More from less was the philosophy of the day. The buildings became meaner, the spaces smaller, access to the outdoors and natural light were not valued then nor are they much now. These are not environments conducive to learning, building and sustaining working relationships. They are places that I do my best to avoid and, when at all possible, leave.

Not long after that calamity, the hospital swimming pool— the closest world away from the turmoil and drama of the ICU and the wards you could ever imagine—was closed. Within a week it was covered with concrete. They certainly can be efficient when they want to!

Eventually, I went back to the ICU; it was close to 4 a.m. There I met Sandy and some of her family. She had become anxious when her husband of thirty years had not returned home from his bike ride so began looking for him, eventually phoning Middlemore. She was distraught when they told her that someone fitting his description was a patient in our hospital. Not knowing whether this was her husband, she told me things about him that I recognised. She then burst into tears when I gave her the medallion he had been wearing around his neck. A short while later, we went in to see him and then returned to the privacy of another room to talk.

Over the next little while I learned more about this man who was refusing to die. He was a family man with four children, and he ran a small successful business. When he was young he was a member of the Parachute Regiment of the British Army and had been a fitness fanatic ever since. Yesterday, he had been out training in preparation for a triathlon later in the year. Sandy described him as a dynamo, determined, committed and when he needed to be, totally focused on the task ahead. As she was speaking I could feel myself nodding in agreement as though I knew him almost as well as her.

Listen to David Galler's interview with Kim Hill on [Radio New Zealand](#).

Things That Matter is available from [Amazon](#), [Allen & Unwin](#), [Poppies New Plymouth](#), [Whitcoulls](#), and [Timeout Book Store](#).

Trevor Lloyd

My Life As A Doctor

By Trevor Lloyd -
January 19, 2016



This piece is based on an assignment for a postgraduate paper on The Nature of Medical Practice. It has allowed me some reflection on my experience of medical practice at different stages of my life. It also gives some valuable background about the context for the other stories.

My Life as a Doctor

Life can only be understood backwards; but it must be lived forwards (1).

It is impossible to write about myself as a doctor without some description of me as a person, in the same way that I would now have difficulty describing a patient simply in terms of their medical condition. This account will therefore be based on a biographical account of my life, concentrating where possible on connections with my medical career.

I was born in Mataura, where my father worked in the local freezing works. Years later I attended a lecture by Professor Dennis Bonham, who had conducted New Zealand's first perinatal mortality survey. He showed a slide of the maternity unit where I had been born, describing it based on its poor performance over the years as "the most dangerous place in New Zealand".

When I was 10, my parents bought a small farm near Cromwell, and we moved to Central Otago. My childhood memories are of helping on the farm, playing in the hills, and

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occasional seaside holidays on the south coast. I remember three or four encounters with different doctors for various injuries and minor illnesses.

I was always a studious child. When I was seven, my parents bought me a set of children's encyclopaedias, which I read cover to cover, often by torchlight underneath the bedclothes. A teacher suggested when I was about to finish primary school that I would get a "better education" at school in the city. My parents arranged for me to attend a school in Dunedin. I went on to Otago University with very little idea of what I hoped to become. One of the senior students at my hall convinced me that if I wanted to keep my options open it was a good idea to do Medicine. I applied for second year Medicine and was accepted. I often joke with family and friends that "I still don't know what I want to do when I grow up".

*I did my best, it wasn't much.
I couldn't feel, so I learned to touch.
I've told the truth, I didn't come to fool you (2).*

Otago at that time was a deliberately traditional medical school. We were taught preclinical subjects with no explanation as to how exactly this information might be relevant to patient care. I suspected that the large proportion of my classmates who had parents who were doctors had something of an advantage. I found the topics interesting, but my marks were disappointing. In my clinical years, there was limited preparation for what were often uncomfortable encounters with other human beings. One especially embarrassing experience was attending the gynaecology clinic. Women attending as patients were required to change into gowns that barely covered their upper bodies, were strapped up into lithotomy position with the referral note by their left foot, and first met the gynaecologist, accompanied by up to six medical students, when he appeared from behind a curtain at the foot of the bed.

When I finished sixth year I decided to work as a house surgeon in Palmerston North. It turned out to be a good choice. It is the smallest city in New Zealand with a university. There were few registrars and no medical students so I got a lot of practical experience and direct contact with senior doctors. Now that I was looking after patients, I began to be influenced by the clinicians I was working with. One was Mason Durie, then a young psychiatrist, now a distinguished expert in Māori health, and a master of cross-cultural communication – Mason once won an award as a psychiatric resident in Montreal where patients voted him as "the doctor who best understands what I am saying", though he claims not to be able to speak a word of French. More significantly, he taught me the importance of making a carefully considered diagnosis, even in a "woolly" discipline like psychiatry, before embarking on treatment. Another clinician who influenced me was John Coutts, a skilled surgeon, who taught me the real importance of knowing "the patient who has the disease" (3). He also had a strong sense of social justice. He occasionally agreed to help out his colleagues with more complex operations at the local private hospital – "little sisters of the rich" he called it – as long as they didn't pay him.

I stayed on as a senior house officer for a six month run in obstetrics and gynaecology to complete my Diploma in Obstetrics. It was a valuable experience, as I was starting to figure out by then what the job entailed. I later returned to the Manawatu for what was then called the Family Medical Training Programme (FMTP). I was lucky during this year, after an extended period in hospital practice where primary medical care was viewed rather negatively, to work with GPs like Lindsay Quennell, Peter Broad and Jim Hefford, who understood the importance of the work they did.

In between, I travelled to England and worked for three years in hospital positions, fitting in 12 months or more off travelling. It was useful working in a different health system and gaining more practical experience in procedures. More importantly, I was able to advance my understanding of culture, history, art and language, all interests that had been relatively suppressed in small New Zealand towns, a boys' boarding school, and probably especially at medical school.

Perhaps with this experience in mind, after my FMTP year I took up a volunteer position as a primary care and rural hospital doctor in Vanuatu (4). This was a life-changing experience in a number of ways: I had to learn to practise medicine with limited resources, relying more on basic clinical skills; I had to learn to manage in a completely different culture, in a country divided by language; and I met my wife, Joan, which has helped me in many ways, including the opportunity for an extended experience of my medical work in that setting.

One useful decision I made during my time in the islands was to begin extramural study in arts subjects through Massey. I started doing papers in literature and linguistics and French language, then switched to a major in education, in the hope that this would help my career prospects. I saw these papers as directly relevant to my work as a doctor. I found I was spending very little time with patients wondering what their molecules were doing, and much more time having conversations with them and trying to make sense of their lives. I also gained new insights into the education system and into learning and development. I found that new ways of thinking, which I believed I had discovered for myself, were already described, and had names.

Back in New Zealand, I worked as a solo GP and rural hospital doctor in Ranfurly. After our first child was born, I moved to a position in Kaeo in Northland, where the work was similar, except there I was salaried and was working with two other doctors. Also it was a predominantly Māori area, which was not all that unusual to me having grown up in Mātaura, but gave me added insight into Māori culture and issues, especially as they related to health care. When our children started primary school, we moved to the city, for me to run the Auckland School of Medicine's general practice in Manurewa and to teach in the General Practice Department. City life was not too bad. South Auckland especially is more of a collection of linked small communities than a large anonymous metropolis, and we benefited from a different range of available activities, and closer connection with Pacific people. Teaching at the School of Medicine helped me to formalise my knowledge of the basic tools of general practice, including communication skills, and gave me some opportunity to participate in research.

I always maintained an interest in rural practice (5). I decided to return with my family to live on a small farm in Central Otago, and work as a doctor at Dunstan Hospital. I wanted to live rurally, I wanted to work in a generalist scope and I wanted my work to be publicly funded. I had no particular interest in hospital practice; in fact Dunstan was the biggest hospital I had worked at for nearly 20 years, and I struggled initially with much of the clinical work. I was lucky to be working with a quality team of doctors and other health professionals, notably Garry Nixon, who has similar interests and values to me but is perhaps more comfortable working within a biomedical framework and has made a greater commitment to learning the details of disease management. I have also been fortunate having a part-time appointment to the Dunedin School of Medicine, which keeps me in touch with the learning needs of younger doctors.

*O wad some Pow'r the giftie gie us
To see oursel's as others see us! (6).*

I don't know what I am like as a doctor; that is for my colleagues and patients to judge. I do know what it is like for me. Medicine I admit remains largely an exercise for the mind, but with the satisfaction of knowing about patients and their lives, not just about their diseases and treatments. I am fascinated by the diversity of people I have encountered, by the connections between them, and by the way they tell their stories. I remain uncomfortable with the intimacy sometimes required, and with intrusive enquiry into various private bodily functions. I don't like causing pain. I don't like taking money off sick people.

I believe that the old-fashioned rural doctor, the kind I occasionally encountered as a child, and the kind I came closest to emulating in Ranfurly, is the classic generic doctor, and the one who has the most to pass on to students. I understand but am disappointed by the withdrawal of my colleagues from areas such as obstetrics, after hours and palliative care. I believe that the type of doctor I have become has been shaped by my medical and other life experiences, and I hope that the way the various bits of this have come to fit together has been clear from my description of significant life events.

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Something to Pass On

By Trevor Lloyd -
January 19, 2016



This story collects together some of my experiences of living and working as a young doctor in Vanuatu. This was a valuable part of my education as a doctor and as a person. I strongly recommend it. The incident I describe is one of many lessons that the people there taught me.

Something to Pass On

I remember that day best as a day I learnt an important lesson, although by then that had become a normal occurrence for me in Vanuatu.

After my year as a family medicine registrar in New Zealand, I had decided to defer the choice of where to settle into practice and had applied for a two year position advertised as a doctor on an outer island. I saw this as a challenging opportunity to work in another culture, to explore options of low technology medical care, and to take some responsibility for the health of a community rather than deal only with illness as presented to me. I was not disappointed.

I worked for the newly independent government, based at a former Anglican hospital, a remnant of the fragmented health service previously administered by the two former colonial powers and operated by various Christian missions. The hospital was built on a beautiful round bay that had once been the crater of a volcano. There was a post office, store and bakery. I received frequent gifts of fruit, vegetables, and fresh fish.

Communication was not easy. The official language is Bislama, a form of Pidgin English, which is highly developed as a language in its own right and is unintelligible to the average English speaker. A willingness to speak in Bislama throughout consultations and at occasional public events was appreciated. However, not all Melanesians spoke Bislama, as they would first learn one of the many local languages. The educated minority also spoke either English or French.

There were few doctors and few resources. During the day we had contact with the larger hospitals in Santo and Vila. Patients could be transferred out by air, but this was not always easy to justify, and at night was impossible. I learnt quickly to cope on my own. There were a

number of patients with tropical infections – malaria, intestinal parasites, filariasis – that I had never seen before and had to learn to deal with. Other infections like tuberculosis were more common than in New Zealand.

One patient, about my own age, but with a young child, had previously been treated for tuberculosis. This seemed to have been unsuccessful. We had admitted her back into the hospital for a few weeks, trying a different range of the available medicines, hoping that she would continue them for a longer period. So far there had been no obvious improvement. There were other family around. The patient's relatives, especially if they were in for some time, would come in with food to cook up for them in the hospital kitchen. Usually they would take turns at sleeping under the bed and at taking care of her son. There was little more that anyone could do.

I also remember that day as the day I had half a haircut. My soft straight hair was always a novelty to the people in Vanuatu. The trouble was, nobody had any idea how to cut it. I discovered eventually that an Australian teacher at the secondary school around the coast had had some experience and would be prepared to do it. Every few weeks, when I thought I had time at the weekends, I would make the journey over to Joy for her to tidy me up.

It wasn't an easy trip. We had a couple of vehicles at the hospital, but they had been donated by aid organisations for public health work in the villages and at other times were kept for emergencies. If I wanted to go anywhere, I had to walk. There were the one Australian, two New Zealand and two British teachers at the school, one Swedish carpenter on the way there, and a Canadian fisherman and his family and an Australian plumber and his wife in the other direction. Until the unexpected arrival at the hospital of an American missionary – we all assumed he worked as a spy for the CIA and had nothing to do with him – that was the total expatriate community. It was a hot half hour or more of walking to visit any of them.

I got good at pacing myself while I walked. The road to the school went up and down between the coastline and a series of little lakes. I knew where there would be shade, and also at which corners I could expect a slight cooling breeze. There were good views down to the sea. As I approached the grounds of the school, I could look down onto the beach and anticipate the opportunity for a swim before I came home. There were always people coming the other way, carrying loads back from their gardens, heading for the shop, or maybe visiting family. They would ask me, as is usual in the islands, "Where are you going?" There is no point, as in more temperate countries, in discussing the weather. I would answer "I am going to the school," and carry on walking.

The teachers always made me welcome. Sometimes somebody would have given them a crayfish or other seafood, and I would be invited to share it with them. We swapped books and ideas and experiences and news from home. Joy was never that fast at cutting my hair – I'm not sure how much of this she had done in Australia really, but I was always grateful for her efforts. She would start on one side and methodically work her way towards the other. While she worked, she chatted away like a real hairdresser. It always ended up looking all right, and she never cut my ears.

On this particular day, Joy had got about half way across when there was the noise of an engine, the screeching of brakes, and a loud knock on the door. It was Paul, one of the nurses from the hospital. I was usually impressed by how the locals always managed to look calm and cool in spite of the heat and difficulty, but Paul that day actually looked hot and

flustered. The young patient with tuberculosis was having trouble breathing; they needed me to come immediately. I abandoned the haircut, said a quick goodbye to the teachers, and returned to the hospital significantly more quickly than I had come.

The patient was indeed much worse. She was weak and unwell and was struggling to get any air in and out of her lungs. The nurses had put her on oxygen and tried some inhalers – we had no nebuliser. One of the nurses, who doubled as the pharmacist and radiographer, had taken an X-ray for me to look at. The X-rays always looked bad, and it was hard to say anything specific about this new one, but as expected it looked worse. I wondered if our patient, on top of her damaged lungs from tuberculosis, had a bacterial infection that we were failing to diagnose and treat. I explained to her that we were going to put in an intravenous line to give her some fluids and antibiotics.

The lady's body and face had shrunk over the course of her illness but her eyes remained large and clear. She looked at me intently, almost pityingly, apparently comprehending but unable to express to me what she wanted to say. She turned to one of the nurses, who was from her own island, and spoke to her forcefully in their own language. "*Hate*" she said, "*nam mate*", meaning, I learnt later, "No, I'm dying." As a final action, she reached slowly into the locker beside her bed, pulled out a small piece of coloured cloth that was folded into a bag containing a few coins, which I believe is all that she owned, gave it carefully to her son, and closed her eyes.

I nodded silently, unable to speak, bowing almost to her greater wisdom. I looked with fresh eyes at her wasted body, which had struggled for too long. I looked at the family members who had gathered to support her, at the nurses, who had understood her situation but had pinned their hopes on my ability to manage it as a medical emergency. I looked especially at her son, who had been standing beside her holding her hand, now clutching his little bit of money, and realised how difficult it must have been for her to come to her decision. I quietly abandoned my ideas of further treatment. The young woman died peacefully later that afternoon.

It was a week or two before I had the rest of my haircut. When I next had some time I made my way back over the hill to the school and Joy finished the job. Afterwards we shared a meal with the other teachers – nothing special, just some rice and fish and fresh local fruit. We talked about the lovely children at the school, the bad news from around the world, how the All Blacks seemed to be struggling at the time, and how lucky we were to be living and working on the island.

A Troublesome Cough

By Trevor Lloyd -
January 19, 2016



My experience working as a solo doctor in the Maniototo taught me a deep respect for the people who live in this remote farming community. It also helped me to develop my ideas about the effectiveness of medical treatments. The incident I describe touches on both of these aspects. It is also, at least in retrospect, is one of the funniest things that has happened to me in medical practice.

A Troublesome Cough

I have never really believed in medicines. I don't take them myself and I don't like prescribing them for others. Even the strongest ones don't seem to make enough of a difference. These days, such a lack of belief wouldn't matter. Our profession is presenting itself as more of a science and less of an art. I could say I was practising evidence-based medicine, and talk eloquently about therapeutic indices or numbers needed to treat. But I have to admit that my aversion to pharmaceuticals has always for me been more of a personal preference.

In the small farming town where I first worked as a GP, this was not too much of a problem. I had a busy obstetric practice; there were various injuries to deal with; at one stage I even went away to distant courses and tried to learn acupuncture. It also seemed to be important, in the consultation, in our relatively remote session, rather than prescribe an ineffective remedy, to pick out those patients who needed referral to more specialised help. Some people of course just wanted to talk. Everybody wanted to talk. Some of the conversations I steered in the direction of getting people off regular sleeping pills or stronger painkillers. I prided myself, as a doctor, on avoiding what I saw as the usual unhelpful ritual of treating illness as recurrent antibiotic deficiency.

All of this must have irritated the local pharmacist. I think he made more money from selling fishing gear and souvenirs. In those days, there was a good margin in dispensing pharmaceuticals from prescriptions, but I didn't write that many. The pharmacy was only open during the week. There was no supermarket and the local general store did not stock, as they would be allowed and expected to do nowadays, a supply of over-the-counter

medicines. We kept a range of these medicines on the shelf at the practice – paracetamol and nonsteroidals for pain and fever, opiates for cough, decongestants for runny noses. These were mainly syrups and were dispensed by the nurses. They had a habit of recycling the empty bottles. When women came in for antenatal checks, for example, they would be asked to transfer a urine sample into one of the bottles for testing.

It was not a bad place to work. We had a good team, at the medical centre – a receptionist and three nurses who knew the community. There was also a small hospital that did a good job of caring for the sicker patients. People were generally supportive of each other and of their doctor. For most of the locals, illness when it happened was an inconvenience, something to be tolerated rather than suffered. When things got too bad, people would come to the doctor with the expectation that they would get some treatment that would immediately allow them to return to work.

I was the only doctor in the area. Sometimes this was a strain, especially when I wanted to get away or had something important to do. Personal sickness could also have been a problem. Fortunately, I kept myself relatively well. In other ways, working alone made my work easier. I got to naturally learn a lot about people over time. Also, many people were related to each other; knowing the relationships between them helped me to understand more about their lives, and to have a better handle on what was going on.

The town was in the middle of a large open basin surrounded by distant mountains. In winter, the hills were covered in snow. Animals found shelter where they could from the cold. Farmers would be busy feeding out hay. The evenings and weekends were spent skating and curling. In summer, it was hot and dry. The countryside was bare and brown, apart from the occasional irrigated paddock. On hot afternoons we would head as a family for the shade of a nearby pine forest for walks through the trees and picnics by the lake.

Most people made a living from agriculture. The soil was poor and most of the farms were large. Traditionally, there had been a lot of intermarriage, which seems to have been less about romance and more about preserving the size of the family holding. As one lady memorably explained to me, prior to me examining her husband that afternoon, “you should understand that we choose our husbands by the acre, not by the inch”. As a young doctor, I found it an interesting and useful lesson. Many of the farmers had been in the region for generations. Other patients, mainly shearers and farm workers, were more itinerant. There were a few visitors and tourists. There was a sprinkling of professionals – teachers, nurses, a dentist – but some of these people also had other connections to the area.

I can’t remember the name of the guy with the cough. He was from somewhere in the North Island. He was a typical shearer: hard working; hard drinking; heavy smoking; constantly swearing; didn’t expect too much from his doctor. He had a few days’ work coming up, as it happened, for the husband of one of our nurses, who had a few thousand sheep due to be shorn. My patient wasn’t sure if he would be able to manage his part of the work, as he had been unable to sleep. I carefully examined him and couldn’t hear anything unusual. We talked about his smoking. Against my better judgement, I went into the nurses’ room and got him a bottle of cough suppressant to take at nights.

Cough suppressants, I’m pleased to know now, are turning out to be probably ineffective; you can’t stop someone coughing without a serious risk of also stopping them breathing. Expectorants are even less useful; you can’t produce a physical change in someone’s lungs

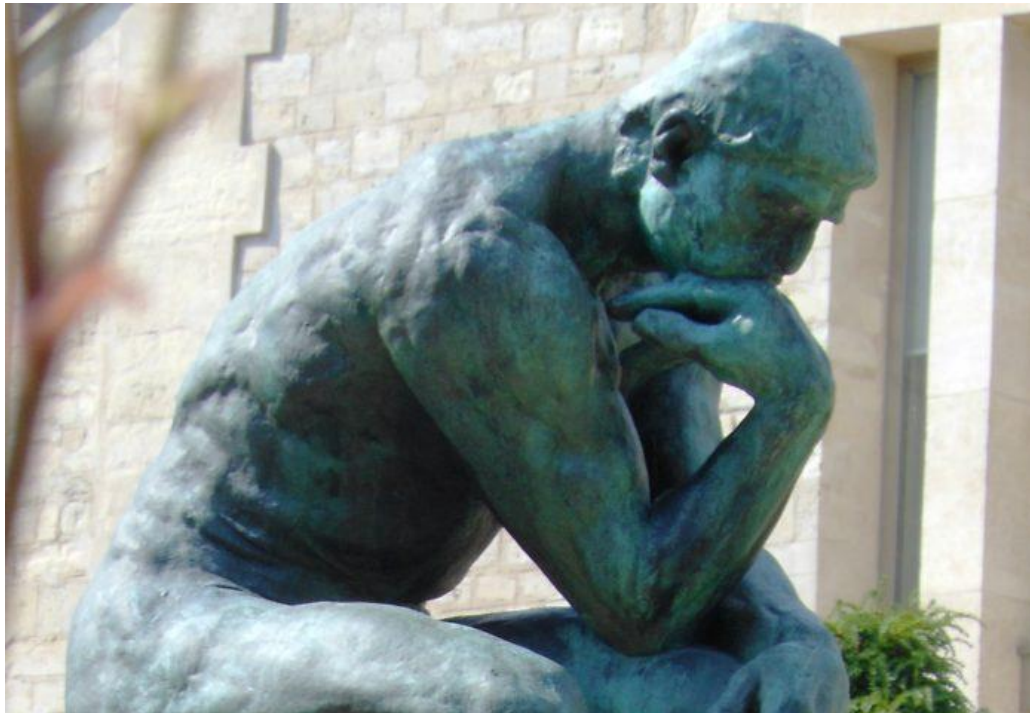
by putting something into their stomach. More importantly, cough is only a symptom. With my shearer patient, someone I had not seen before and might never see again, I should at least have been thinking about asthma, reflux, cancer, even tuberculosis, and taken a much better history.

It was a busy afternoon. It is always busy when things go wrong. I may have already been running behind time when I saw him. He may not have booked an appointment, and I had had to squeeze him in. I may have been called to the hospital to deliver a baby. I may have gone out to a car crash or some other emergency. I may have been up all night looking after a patient. Or maybe I had just been having one of those long conversations with an earlier patient about the meaning of life and the disadvantages of taking regular tranquilisers, and been running late.

I'm not sure when we noticed my mistake. Probably it was when the nurse who was on that day returned to tidy up and wondered what had happened to the urine sample she had left on the shelf, in its medicine bottle, after testing. Certainly we heard about it a few days later when the other nurse returned from looking after the shearers. Our man had been fine. He had got through his heavy shearing work without incident. He was recommending my excellent care to the other shearers. The syrup I gave him off the shelf had cured his cough. It "tasted like piss" he said, but it was the best cough medicine he had ever had.

Un Peu de Poupart

By Trevor Lloyd -
April 10, 2017



Un Peu de Poupart

They say that French is the language of love. Whatever their experience, many people associate it, in their minds, with romance, passion, and faraway places. German, which to my mind is just as beautiful, is dismissed as 'guttural'. Perhaps this is because the two major wars fought against Germany are more recent than Britain's long-running and recurrent skirmishes with the French.

I first heard French spoken by my first 'girlfriend'. We were both seven years old at the time. We were at primary school in a town in rural Southland. Jackie's father (maybe it was Jacky, but I admit I prefer to use the French spelling) had been posted there as the local bank manager. They had lived in more desirable places, including in a French-speaking part of Canada. Jackie taught the class some French words. I was impressed that she had available to her alternative terms for everyday things such as colours and animals, and a secret code that could be used for communicating with others. Of course our romance didn't last. Jackie's father soon found a better job and they moved away.

I remained fascinated with language. Ironically, I could have had a similar experience by getting to know the Māori families in the mainly freezing works town. I could have made an effort to learn their language, which many Māori in those days probably spoke a bit of at home or at least on the local marae, but at the time, to my shame, it didn't have the same appeal.

My chance came when I was sent away to attend a boys' boarding school in the city. Those of us identified as more able pupils had to learn French and Latin. I devoured it. I spent hours

writing out French words and their English equivalents, and learning the silly little details, that I had never noticed in my own language, of what had to agree with what. I received the prize each year for the top French student. The result now, as it is for most school pupils around the world, is that I am good at reading French, and could probably write it correctly, once I got back into it, but struggle to speak it, and in a real conversation have little idea of what other people are saying.

Did it bring me love? Certainly not the love of my school-mates. Life was tough, and academic success was envied rather than valued. I was made to feel unusual. I got beaten up whenever I passed anything. There was no opportunity to experience the love of my family, who were far away, and with the best of intentions had put me into this situation in the first place. Girls? I didn't know any. Sporting ability would probably have been more admired, but I struggled on with the ability I possessed. Required to specialise in my later years at school, I opted for mainly science subjects, but chose to continue with French rather than biology (this was something of a disadvantage when I decided to study medicine, but I managed).

Eventually, later in life I did get to travel in France. Although I had done all that study at school, I found I needed a phrase book to learn what people actually say in real life. I spoke French, I had to admit, *un peu* – a little. Later still, I got to work in Vanuatu, where a proportion of the population are educated in French. Understanding written French was an advantage. I was working with some French doctors and other health professionals. Most of them could speak to me in English, but it was sometimes useful to communicate with their spouses and families using French.

I had limited opportunities to travel at the time when I was a student. We had little money in those days, and there were no student loans. I didn't travel to the North Island till I was twenty, and then only to fly from Auckland to Fiji. This was to spend a few weeks with a friend who had family working at the university there. We somehow got to Wellington, I think on the Cook Strait ferry. Then we set out to hitch-hike from there to Auckland. I shouldn't judge from this one experience, but it seemed that people were less friendly and helpful than in the South Island, and were making shorter journeys. We made slow progress.

We got as far as Waiouru. It was cold and dark. We found that if we waited at the station we could catch the overnight train from there to Auckland. We were happy to take this opportunity; it had been a long day. On the train, we were pleased to meet two girls. I can't remember their names. Like many of the details in this story, I shall make them up. Let's call them Janine and Marie. They were from Tahiti. One of them had family in Auckland. They were flight attendants, they said, having a look at other parts of New Zealand between flights. Tahitians? Flight attendants? Is there to be a happy ending?

Tahitians, since the days of the early European explorers of the Pacific, have famously been the object of stereotypes and fantasies. Captain James Cook documented in his journals the interaction between his sailors and the Tahitian women. When the sailors first arrived, he wrote, the women would willingly sell their bodies for one nail. Then the price went up, the store of nails ran out, and the men started pulling nails out of the ship's planks. Cook had to put a stop to the practice to prevent the ship falling apart. Some of the men had to be locked up, or flogged, or both, to stop them disappearing into the bushes on other parts of the island to live with their Tahitian 'wives'.

The French, although they later criticised the British for their exploitation of the local people, were no better. They appropriated the island in 1842 as part of French Polynesia. Probably

the best known images of Tahiti are the paintings of the French artist Gauguin, depicting colourful, exotic, half-dressed women. Gauguin eventually died on the island, of syphilis.

Flight attendants, over the years, have similarly been the object of stereotypes and fantasies. People tend to think of the imaginary ones portrayed in film or on TV rather than the real ones on their last flight to Auckland or Queenstown. Some people confuse the two. A few years ago a prominent New Zealand doctor was jailed for, among other things, acting out his own fantasies. Enough said.

The girls spoke to each other in French, which – though we didn't let on – we could partly follow. They also taught us a few words of Tahitian, giggling each time they thought of another example. One word I especially remember was '*poupart*'. I'm sure in Tahitian it is spelt more simply – their language is closely related to Maori. But the girls gave it the full French flourish, with much movement of their mouths and arms, and a soft purring sound at the end where you could imagine one or two other letters might be. They said it meant 'hello'. Another word, they said, meant 'thank you'.

The train stopped near Hamilton. There was time to buy refreshments: a pie; a soft drink. I think by that time they had stopped selling tea in those solid china railway cups. Marie decided to get off and purchase something. She enquired of Janine, "*Tu a envie de quelque chose?*"

"*Avoir envie de*", as any French teacher will tell you, doesn't mean 'to have envy of' but 'to have want of'. There was a famous *faux pas* by one of the British Prime Ministers, John Major I think, in a speech to the French Prime Minister at the time, probably Edith Cresson, in front of a French audience. There was some little thing that Major envied about Cresson, so he famously inserted into his speech, foolishly practising his schoolboy French, "*J'ai envie de votre Premier-Ministre*", meaning to the French crowd that he 'wanted' her.

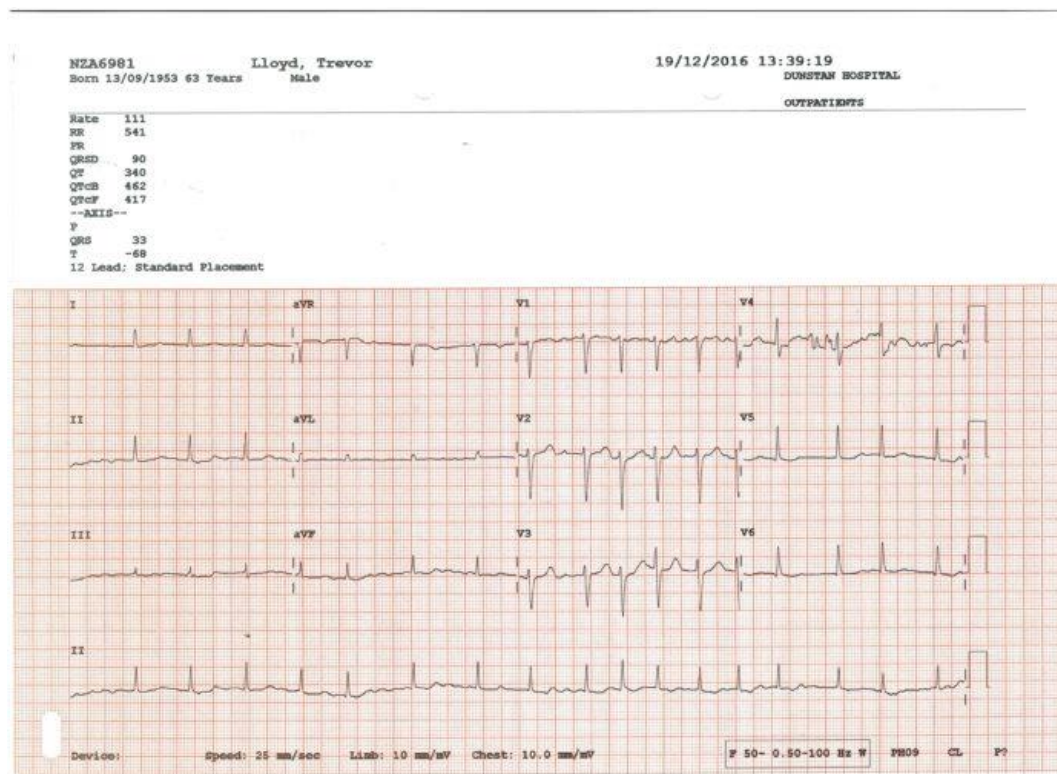
It was the same expression. Marie was simply asking Janine if she wanted something. Janine's answer surprised and delighted us. She did indeed have *envie* of something. She glanced in our direction, back to Marie, and replied using 'the language of love', which I think she believed we wouldn't understand, "*Oui. J'ai envie d'un peu de poupart*".

There is limited opportunity, unfortunately, on a crowded train, even at night, for much in the way of *poupart*, whatever it is. There is only so much you can get away with. The time from Hamilton to Auckland did seem to pass fairly quickly. Looking back from a future that has included more experiences of life, and chances to reflect, it's the thought that counts. Sometimes all we are left with are stereotypes and fantasies, and an augmented memory of long-ago events.

Janine's mother met the two girls at the railway station. Probably to their surprise, she was interested to meet us, and invited us to lunch. We had a lovely meal out on the veranda overlooking the garden. It was fresh island-style food – an appropriate preparation for the next stage of our trip. We were of course very grateful, and expressed our thanks to our host. The bit I remember best is the girls' discomfort when we suggested that we should thank Janine's mother in Tahitian, which of course in our genuine gratitude we would never have done, using the words that the two girls had taught us.

A Shocking Experience

By Trevor Lloyd -
December 13, 2017



A Shocking Experience

A rare disease is said to be a common experience for those who have it. A common disease, I have discovered, feels equally rare for someone who is not used to being sick.

In Central Otago, we have a high prevalence of heart disease. We have a large population of retired people. Many of them have sold farms in Southland or South Otago, and left to come up here. They move to our drier climate as soon as they don't need the rain to grow grass to feed sheep or cattle. They have eaten mutton and cream all their working lives, but have been reasonably active. At some time after their retirement, they start developing heart problems. Often this takes the form of a major heart attack, which for most of them is unexpected.

A quick glance at the patients' past histories typically reveals that this is not their first encounter with the health system. Most of them have had hips replaced, hernias repaired, hysterectomies or prostatectomies, tonsils or appendices removed, or are on treatment for high blood pressure or thyroid deficiency. Some have allergies to medicines. I have previously prided myself on having none of these things. I imagined that if I ever had to go into hospital I could impress the junior medical staff, and make their job easier, with my completely clean medical record.

I have been reasonably fit. I am 64 years old. I weigh 105kg. Some of this extra weight, I claim, is muscle, from years of walking, running, biking, skating, skiing, swimming and working on the farm. Most of it, I admit, is fat, from overeating. I like to eat. That has been

my only health problem. Nevertheless, I have become convinced that, unless I can find some way of getting taller, which is unlikely, my only way of achieving a more respectable BMI is to eat less food. I have never smoked. A drink when I have one, which is not every day, is almost always just one.

In 2014 I ran two marathons. I had run one before, in 1992, when I entered in the Auckland Marathon. It was the first time runners were allowed over the harbour bridge. Probably motivated by one of my brothers, who told me he had run a marathon in “three hours 75”, I managed to complete the Auckland course in under four hours. The new me, in the 21st century, I am embarrassed to say, was taking well over five hours. My wife waited for me at the finish lines in Rotorua and Queenstown. When I expressed my disappointment at not approaching my earlier mark, she helpfully explained that I was “younger and slimmer then”.

My resting pulse is usually well under 40. I don’t think this on its own is a sign of fitness, but the rate does go down a bit when I have been training for something. I can feel my heart beating when I am lying in bed. Sometimes I would amuse myself, before getting up and facing the day, by taking my pulse.

All this changed on the 1st of December 2016. My heart through the night felt different. I was aware of extra beats. When I took my pulse in the morning, it was completely irregular. The experience of taking my pulse is perfectly described by one of my co-conspirators Glenn Colquhoun in his poem “Heartsounds”:

The heart

bangs

like a door

in the wind at

the

back of

the house.

My feelings though, as a result of my own “door banging in the wind”, could be better summed up in a rhyme from childhood that kept coming into my head:

A peanut sat on a railroad track.

His heart was all a flutter.

Round the bend came number ten.

TOOT. TOOT. Peanut butter.

My first reaction was one of denial. Palpitations are a symptom for the worried well. They are usually the result of ventricular ectopic beats, which go away when we move about and our hearts speed up. In young fit people, with no history of heart disease, they are harmless.

I convinced myself for two or three days, over the weekend, that this was all that was happening. Then I went to Cromwell Medical Centre for an ECG, which appeared to show atrial fibrillation, but with a few P waves. Isla, one of the GPs, agreed to see me. First though she showed my ECG to the four other doctors working there that morning, who all agreed that it was typical atrial fibrillation, or AF, with bits of atrial flutter, making further denial impossible.

Atrial fibrillation is an interesting condition. Which is bad. If you have to go into hospital, try not to have an interesting condition. It will probably be difficult to diagnose and treat, and require long lists of uncomfortable and inconclusive investigations. The American Heart Association guidelines for AF run to more than 120 pages. More useful was a patient information pamphlet at work from the New Zealand Heart Foundation called “Living With Atrial Fibrillation”, which I picked up supposedly for my wife to look at, but read from cover to cover myself, which was helpful. It said about 300,000 New Zealanders have AF; I wanted to go back to being one of the 4.3 million that don’t. The pamphlet listed all the risk factors, starting with the usual suspects – age, obesity, and drinking alcohol.

We didn’t use to worry that much about AF. There are medications to slow it down. Of concern, people with it have five times the risk of stroke, but this can be reduced with anticoagulants. As a profession, we then went through a period, including where I work at Dunstan, of trying to get everybody back into a normal rhythm, for every episode: with Amiodarone, which can damage people’s skin, thyroid, and lungs; or Flecainide, which can precipitate ventricular fibrillation and cardiac arrest; or a shock from a defibrillator. Then, after some major trials showed that these repeated attempts were impairing people’s lifestyle, and didn’t help in the long term, we started being more selective with our interventions.

I decided at an early stage that atrial fibrillation and I were not meant for each other. Isla referred me to the cardiologists in Dunedin Hospital to see if they could restore me to a normal rhythm. She also started me on Dabigatran, to dissolve any clots that might have formed in my heart and might become dislodged by the interventions. Isla asked me what I was like at taking pills twice a day. I said I didn’t know – I hadn’t tried it before. I turned out to be really bad. I kept forgetting when I had not taken the pill, or even if I had. The pills have to be taken with food, and not immediately before lying down. One night, after working the previous night on call, I went to bed straight after my evening meal. I woke with terrible heart burn. We don’t have any antacids or proton pump inhibitors in the house, so I rummaged round the kitchen pantry in the middle of the night to get some baking soda, which relieved it.

Worse, I had become a PERSON ON PILLS. With side-effects. Apart from the nausea and heartburn, I was at risk of bruising or bleeding. This was possibly dangerous. I drove more carefully. I stopped biking. I limited my farming activities so as to avoid injury. I paid one of the neighbours to crutch my sheep. They usually kick me if I don’t hold them properly, which is often, and I end up with bruises all over my legs. I decided that this time the sheep could kick someone else instead.

With Christmas coming up, Isla also referred me in the meantime to my colleague Garry, who has a special interest in cardiology. He is known as “Guru Garry”, except perhaps by actual cardiologists. I asked him if the cardioversion could be done where we both work at Dunstan. He was reluctant, not only because we work together, but because of his concerns about my airway. A few years before, when we were both teaching in the Hokianga, he had

been trying to sleep beside me on a marae, but had been kept awake all night by my snoring, and by some disturbing gaps in my breathing pattern. Having experienced my breathing after a few beers at the Omapere pub, he wasn't willing for our staff to have to manage it after an anaesthetic.

I managed to get an ECHO from Wendy, our visiting echocardiographer, whom I also know well from her involvement with our teaching. She found my heart was going faster than expected, and my left atrium was a bit enlarged, but was optimistic about the chances of going back into a normal rhythm. There is something relaxing about the closeness of physical examination. With Wendy's arm wrapped around my chest, to get the probe into an ideal position for an apical view, it was easy to talk about my hopes and fears. Many people have commented that it must be difficult for me to be a patient, having become used to being the doctor. It's not; I have been a doctor for over 40 years; I don't know what it is like to be an adult who is not a doctor. What I do find difficult is that I am not used to being sick.

The cardiologist, John, after receiving Isla's referral and Garry's letter, kindly agreed that I didn't need to make the six-hour round trip to be seen at a clinic, but could come down when an anaesthetist was available for them to do an electrical cardioversion. An opportunity came up within a few days when there was a cancellation. It was on Friday the 13th – an inauspicious date. “Did somebody die?” my wife asked. “No,” I explained, having been reassured by the cardiology secretary, “somebody went back into a normal rhythm”.

I was supposed to be working the next day. I texted my boss, Lisa, to say I would be late. She gave me a couple of days off instead. I checked the instructions. They did say not to drive or operate heavy machinery for 24 hours after the procedure. There was nothing about not practising medicine, but we thought it best to be on the safe side.

In Dunedin, I was shown into a room with three (other) old men. They looked like the patients at Dunstan. Luckily, none of them was. I changed into my one-size-fits-all gown and shorts. There was someone else's blood on the floor. The nurse pulled the curtains around our beds to create an ineffective “cone of silence” while she took our histories. Nobody realised I was a doctor, though they must have had their suspicions when John came in and had a detailed technical discussion about my options. The anaesthetic team arrived and obtained my consent. “You don't want to be awake for this”, they said. “If you want to be anaesthetised, you have to consent.” It felt like an offer I couldn't refuse. The house surgeon took some more history, picked I was a doctor, examined me, then nervously explained the procedure, including the risk of a further arrhythmia, stroke, or death. It felt strangely reassuring to be so fully informed.

The time came. I was wheeled down in my bed to another room. A robotic voice in the lift intoned the words “going down”, and we did. I have never had an anaesthetic before, and I didn't enjoy it. There was the claustrophobic feeling of inhaling too much oxygen through a tight-fitting mask, a stinging feeling in my hand from an injection, then trying to stay calm while drifting off into an uncertain future. Defibrillation, they teach us at advanced cardiac life support courses, is not a way of restarting the heart, but of stopping it and waiting for it to restart itself in a normal rhythm. I was determined not to think about it.

I eventually became aware that I was in another different room, with another set of different people, like coming out of a dream without having slept. I have been unconscious once before, after being winded at rugby, and it was a similar feeling. A nurse I hadn't met before was standing beside me and told me that I had been given a single shock, which had

restored my heart to a normal rhythm. The anaesthetists came past and told me they had given me Fentanyl and Propofol – “mother’s milk”, the stuff that had killed Michael Jackson (though, as it happened, they didn’t tell me that bit). My blood pressure had dropped briefly, but there had been no problems with my airway. I was returned to the ward, slowly got dressed, and my wife drove me back to our motel. I wanted to escape before one of Dunedin Hospital’s re-heated meals, which I had heard so much about, arrived for me to eat.

I was warned to expect mild skin discomfort. I got this. If you do want to make someone’s skin uncomfortable, I would recommend sticking a patch to it then passing a strong electric current through it. I also experienced a strange overall muscle stiffness. I don’t know if this was from muscle contraction associated with the shock, or from the anaesthetic. I went for a slow careful walk in the gardens to see if I could clear my head. I found it difficult to sleep. The next morning, I woke a few minutes before we had to check out of the motel, with no idea of what time it was. We drove back home. The following afternoon, after another short walk, I lay down for a rest, went to sleep, and was only awoken at 7pm by people arriving for an important meeting. Something funny had happened to my brain that had interrupted the normal rhythms of daily life.

I stopped drinking coffee and alcohol. I tried harder to eat less food. I was worried about exerting myself, so did some research. I was alarmed to find the extent to which physical training increases the risks of AF. People without other forms of heart disease who do more than three hours a week of vigorous physical activity have five times the risk of AF. Overall mortality starts to increase in those who run more than 24km a week, and at longer training distances, and higher speeds, approaches the mortality of those who do no exercise at all. I wasn’t sure what to make of it all, except to wonder why nobody had told me this before. I was reassured to find that AF in the more active group is not usually precipitated by exercise.

It was surprisingly difficult to cut down on physical exertion. Eggs Benedict without coffee, curry without beer, steak without red wine, I supposed I could get used to. But living in Central Otago without enjoying mornings running along the lake, or afternoons biking into the hills, didn’t seem fair. I decided to devote more time to doing it slowly. Instead of stacking all my hay on the day it had been baled, working into the evening, I spread the work over three days. I promised myself more time off for leisurely walks instead of fitting all my mileage into long runs.

I returned to work. I needed some more investigations. I had an exercise test one morning while on the ward, without putting myself back into AF. Next, I had to wear a Holter monitor for 24 hours. This included keeping a diary of my activities during this time, which was the hardest bit. I have never been very good at documentation. I tried to find more noteworthy things to do than sitting reading or watching TV. Any more interesting activities – I had to wear the monitor in bed – were pretty much precluded by the unattractiveness of the leads on my chest attached by wires to a box on my waist.

After about six weeks, to give my heart time to settle down, I had another ECHO. Except my heart hadn’t really settled down. My left atrial size, which had been “a bit” enlarged before in AF, at my normal slower rate had increased from 45 to 47 millimetres. I checked with Wendy if that meant I was more likely to go back into AF. She said it was a certainty.

Then, for a long time, nothing happened. I counted the days. Eight weeks passed, then two months. I seemed to be in sinus rhythm. I didn’t go back to Isla, or Garry, or John, who were

probably all leaving it up to each other to follow me up and do anything else that might be required. Except that nothing was required. I asked Garry on the ward if he had any new information. He didn't. After ten weeks, I emailed John, the cardiologist, who gave some helpful advice. He recommended "watchful waiting". He described the lifestyle changes I had made as "sensible". He had "no doubt" I would "revert to AF at some point". "The question" he wrote "is when". It is easy to be realistic and honest, which I guess is what I needed, when writing an email.

Reflection, including writing this story, has helped me to put the episode into perspective. My condition was trivial rather than tragic, distracting rather than dangerous, but I still found it quite disruptive to my usual routines. And I am still mourning my loss of perfect health. It was interesting and instructive to see the health system from the other side. My overwhelming impression was of knowledgeable, competent, and caring people, who were happy to help when required. I like to think the experience would be the same for people who are sick and who don't happen to be doctors.

Return to Paradise

By Trevor Lloyd -
December 21, 2017



Return to Paradise

It is a requirement for vocational registration as a rural hospital doctor to work at least one week each year at another hospital. This year, I decided, I wanted to go back to Vanuatu, where I had worked for two years in the 1980s, and spend two weeks at Northern Provincial Hospital in Santo. More than 30 years after my first visit, I found that much had changed.

The island of Santo is the largest of the country's 80 or more inhabited islands. It was named by the Portuguese explorer Pedro Fernandes de Queirós, who established a settlement there in 1606. He believed the land he had discovered was the edge of the long-searched-for great southern continent, and called the island group La Austrialia del Espiritu Santo.

The American author James Michener was sent there as a war correspondent in 1940, to the country then called the New Hebrides, since renamed Vanuatu. He was stationed mainly in Santo, a major base for American and allied troops during World War II. While there, he wrote his first book of short stories, *Tales of the South Pacific*. He starts by writing about his surroundings:

"I wish I could tell you about the South Pacific. The way it actually was. The endless ocean. The infinite specks of coral we call islands. Coconut palms nodding gracefully towards the ocean. Reefs upon which waves broke into spray, and inner lagoons, lovely beyond description" (1) p.9.

The book was adapted by Rogers and Hammerstein into the musical, and later film, *South Pacific*. Michener was fascinated by the strange mix of cultures he encountered, especially

the dual colonisation by Britain and France. He came back to the islands after the war to write *Return to Paradise* (2) and *Rascals in Paradise* (3), and went on to write more than 40 books selling over 75 million copies.

From Santo, Michener looked out to a high island in the east, often shrouded in cloud. Bougainville and Cook, and the early missionaries, called it Leper's Island. The local name was Aoba or Omba, and is now Ambae. Michener called it Bali Hai. He imagined it as populated with beautiful women, mainly the daughters of expatriates in the New Hebrides at the time of the war, but it was also the site in the musical of the libidinous "coconut feast" with local Melanesian women, and of the fictional romance between Lieutenant Joe Cable and a Eurasian girl Liat, the daughter of the scheming Bloody Mary.

Back in 1983 and 1984, I found myself a job on Ambae, based at Lolowai, a former Anglican mission hospital at the eastern end of the island (4). Michener never went there, and it is a bit different from what he described, but it is indeed a special place, and working there as a doctor was a wonderful experience. Michener was right about the beautiful women. My wife, Joan, is from the island; her people have been in the area for thousands of years.

This year, the volcano in the middle of Ambae started erupting. The entire population of the island – numbering more than 10,000 – was evacuated, with people leaving behind their homes, schools, churches, possessions, food crops, livestock, and in some cases small businesses. But that's another story.

We have returned many times to Ambae over the years to holiday and visit family. I have also been back to Vanuatu on other occasions. In 2015, we attended the Pacific Medical Association conference in the country's capital, Port Vila. Another time, I worked as a volunteer doctor at Vila Central hospital. This time, it was Santo.

Santo, as compared with Port Vila, has a feeling of capacity and potential. It is becoming an increasingly popular tourist destination. The main town of Luganville has a wide main street, left over from the war. There are two bigger hotels in town. One is the Espiritu; the other is the Hotel Santo. We stayed at the first one. There are smaller less comfortable places. The Espiritu is a modern establishment, owned by a young couple, one of whom is a New Zealander, and comes complete with a big screen at the pool-side for watching All Black test matches.

The hospital in Santo is older and less well staffed than the one in Port Vila. There are four ni-Vanuatu doctors. One is a surgeon; one is a specialist anaesthetist, but works mainly in administration; the others are an obstetrician and a physician in training. There is one paediatrician from Papua New Guinea. For reasons that nobody understands, there is also a Chinese doctor working in each specialty. Most of the clinical work, especially in the emergency department and the non-communicable diseases clinic, but also including some low-risk anaesthetics, is done by nurses.

Most of the time at the hospital I worked with Dr Lawrence Boe. He is a medical registrar working towards specialist registration as a physician, but with no real opportunity for supervision. Lawrence is from Maewo, an island to the east of Ambae. I had visited his village regularly while working at Lolowai. He had been delivered by the nurse at the clinic there a few years after I left.

The first patient I met on the ward was a twenty-year-old girl who had come in the night before in status epilepticus. She had had life-long epilepsy but while on an outer island had been well controlled on Phenytoin dispensed by a nurse at the local dispensary. She had moved to Santo to a “custom village” where the residents had rejected the trappings of a Western life-style, and had stopped her medication. The seizures had been terminated in the hospital with intravenous Phenytoin, and she had been started back on pills, but was unhappy about remaining in hospital. She started calling out and having bizarre brief twitching of the left side of her body. In between times she was normal. We couldn’t tell by looking at her if these were seizures, or some odd behavioural episodes. Phenytoin levels are not available. While we were contemplating whether to increase her Phenytoin to more than her previous dose, or start another anticonvulsant, her father insisted on taking her home to the village to try traditional medicine. This would have consisted of a mixture of herbs and measures to combat magic spells. It may or may not have been more effective.

Next was an older woman who continued the theme of non-compliance. She had diabetes and had previously had a below-knee amputation. She and her husband had gone “to the bush” without her insulin, which up till then had been injected by her daughter. She had turned up at the hospital with hyperosmolar coma. The first two days we saw her she was aphasic. Once she regained the power of speech, she complained bitterly and constantly, mainly to us about not having a “fake” leg. She got into a heated discussion with the ward charge nurse, who told her she was “lazy” and not having an artificial limb was “just an excuse”. The woman argued that it was her family, who were sitting around her bed at the time, who were “lazy”, and not looking after her properly. The other patients in the four-bedded room, and their families, found all of this hugely entertaining, and kept laughing and interjecting. Eventually, a truce was called, and the woman went home.

After the ward round, we were supposed to see patients who returned for review. This did not always go to plan. The first day, six patients were booked for review. Only two of them showed up, but one of them had no records. The staff seemed relieved about one of the no-shows. She had been admitted two weeks before with chest pain and uncontrolled hypertension. She had written in her own notes about “too much noise” on the ward increasing her blood pressure, demanded a private room, then had locked herself in so that the nurses were unable to get in to do her observations. She did turn up three days later and was briefly reviewed by one of the doctors.

There has been a huge change over time in the pattern of disease in Vanuatu. When I worked at Lolowai, we had to work with the effects of communicable diseases, such as malaria, tuberculosis, filariasis and leprosy. Now, a little more than thirty years later, at least in the town, people have mainly non-communicable diseases. There is a huge burden of hypertension and diabetes, much of which is unrecognised or poorly controlled. Half of the patients on the ward had heart failure. They had presented at a late stage, which meant that treatment was mainly palliative, but Lawrence and the team did their best to manage them. To make things worse, there is no cardiac monitor, ECHOs can only be done in Vila, and pacemakers, angiography, and cardiac surgery have to be done for selected patients in Australia or New Zealand.

An additional problem with limited resource is that there is no public provision of physiotherapy or rehabilitation services. A young woman with paralysis from the waist down was discharged into the care of her family, with no additional supports available, and had to buy her own wheelchair. She probably had a transverse myelitis, but it is hard to say without the benefit of further investigations – there is no CT or MRI in the country. Amputations are

common. Many people have poorly-controlled diabetes and present late with sepsis, which leaves few other options. The limb clinic has only one staff member, who does not have the materials to make or supply prostheses.

The country is moving from subsistence agriculture to a cash economy. People no longer grow all their own food. Starchy staples such as taro and yams, which are difficult to grow and prepare, are being abandoned for imported foods such as sugar and flour and white rice. It is easy to buy bread sticks and donuts in the shops. The change in life-style is obvious from the litter on the street. It is about a twenty-minute walk from the town to the hospital. The path is strewn with Coke, Sprite, Fanta and beer cans, lolly papers, biscuit wrappers, and cigarette packets. If archaeologists investigate the site in a few hundred years, they will have no difficulty determining how all the people died.

Towards the end of the first week, I met Dr Basil Leodoro, the director of medical services. He had been down to Port Vila to operate on three patients who could not be safely anaesthetised in Santo the previous weekend. We had an enjoyable lunch at the Espiritu. We have much in common. Basil is from Lolowai. My wife's family are distant relatives. Basil knows a few of my colleagues in New Zealand and in other Pacific countries. Over lunch, we shared many memories, and some ideas about how we could do more things together in future.

Basil invited me to his house to drink kava with his father, Albert Leomala. This was not something to be turned down. I had fond memories of drinking kava with my father-in-law on Ambae. I had less fond memories of its unpleasant taste and its strange numbing effects. The actions of the drug are augmented by eating, sometimes to the extent that the recipient is unable to move. Once we had finished the kava, Basil dropped me back to my hotel, where I would be safe, with a parcel of food.

Albert had been born at Lolowai, but had moved to Port Vila a couple of years before I worked there. His father, also called Basil, had trained in Fiji, and came to work at the Anglican mission at Lolowai as one of the first indigenous doctors. Albert had become a teacher and was also an inspiring and influential poet. An early work (5), prior to Vanuatu's independence from Britain, displayed a strong rejection of the colonising efforts of the Christian missions.

*"Cross, I hate you
You are killing me.
You are destroying
My traditions.
I hate you Cross.*

*...
You thought you were clever
But you never thought
Of my cleverness.*

*...
Take your ideas
And your civilisation
And go back
Where you belong."*

Another poem (6) cleverly contrasted the previous two colonial administrations, with their two-word names for the country – New Hebrides or Nouvelles Hébrides – and the proposed independent single government, with its choice of a one-word name: Vanuatu.

*“Land of my fathers
Should I kiss you, or should I spit on you?
Should I spell you one, the black way,
Or two, the white way?*

...

*Forced to swallow
Noisy beefeaters
Gluttonous frogs
Lecherous kiwis
And money-sucking kangaroos?”*

This was a man I had always wanted to meet. We talked into the evening of our different lives, of the connections between us, and of how I had come to marry Albert’s younger relative. I guess that makes me a lecherous kiwi.

I had time at the weekend for some tourist activities. On Saturday, I took a taxi out of town to one of the “blue holes” – fresh water springs in the bush naturally coloured by copper salts. On Sunday, I took a ferry to the resort on Aore Island, where tourists are happily imprisoned for a few days in seaside bungalows. The beach is kept in pristine condition by hard-working ni-Vanuatu men with rakes and wheelbarrows, and there are an unnaturally large number of tropical fish feeding on the dying reef.

Also on the ferry was Dr Yan Guowei, the physician on call for the hospital. Dr Yan spent three years in Tanzania prior to coming to Vanuatu, so he speaks a few words of English. His surgical and anaesthetic colleagues worked instead while in Africa in the francophone country of Cameroon, so attempt to speak in what the ni-Vanuatu doctors call “French” – using their fingers to indicate quotation marks – or “some French words”.

There are still a few French people in Santo left over from the colonial days. The country remains a popular destination for French tourists. A genuine French couple, Patrick Dancel and Cécile Paintoux, from Tours, in the Loire Valley, run the excellent Aore Art Café (6). The food is good, and the view through the garden across the harbour is one of the best in town, but their real passion is photography, and they have travelled the world creating beautiful images. Patrick made a living in France selling pictures to doctors for their waiting rooms. Cécile took the photo of Port Olry that I have used to illustrate this story, and gave me permission to use it for this purpose.

Our last evening on the island Joan and I spent at le Village de Santo, a resort on the edge of town, which sounds French, but isn’t. Strangely, the owner is Egyptian. To add some symmetry to our experience of the European occupation of the country, the restaurant is called 1606. It serves island food with a Portuguese or Spanish twist, and has interesting drawings of de Queirós around the walls. It was a fitting end to our time on Espiritu Santo.

James Michener, writing in *Return to Paradise*, gets the last word:

“Of all the islands in the Pacific, Santo has made the most profound impression on me. There are lovelier islands, true, but the main reason why I like Santo is its zany life ... I was sorry to leave” (2) p.215.

I was pleased to have again had the opportunity to visit the island and experience the strange mix of cultures that Michener and others have found so endearing. I got back on the plane to snowy Queenstown, happy to have had another opportunity to spend some time back in the country that has given me so much over the years.

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Alistair Macdonald

Woody Guthrie's Role in My Not Being a Psychiatrist

By Alistair Macdonald -
June 27, 2016



I am now a retired renal physician. The Medicine Stories Project struck me as a fantastic idea. I have always thought that one of the important things that was missing in medicine was the narrative. This story reflected the fluid nature of how important it is to make decisions on the basis of one's own experiences. Louis Pasteur said "Chance favours the prepared mind" On reflection I think in my own discursive fashion this is what I think my thoughts were at the time.

Woody Guthrie's role in my not being a psychiatrist

Convention has it that the Sixties began in 1960. But take it from me, the Sixties began on the morning of October 5th 1962 when the Beatles released "Love me do." In response, popular music experienced a seismic shift from songs based on a saccharine sentimentality to music full of gutsy, hard edged, reality. Not long afterwards you needed to aggressively define yourself based on whether you worshipped the Rolling Stones or the Beatles.

The idealistic, love-in, drug hazed, fashion show that followed ended abruptly when the Union Nationale des Etudiants de France (UNEF) demonstrated in the streets of Paris in May 1968. The city came to a halt. There was a risk of an armed rebellion. De Gaulle called a general election. Ironically, he won a landslide victory but resigned at the end of 1969. The world was never the same again and the Sixties ended.

If there was any doubt that the Sixties were moribund, the stabbing death of Meredith Hunter at the Rolling Stones concert in Altamont in 1969 by the Hell's Angels was an epitaph. For such a thing to happen four short months after Woodstock confirmed that the bubble had indeed burst.

So what's this got to do with psychiatry? Well, taking a few steps back ... It's not widely known that the Sixties pretty much lasted the same time as I spent as a medical student in Edinburgh. I realised very early on that this flux of ideas the Sixties were throwing up was likely to be quite an interesting experience. My father had been a successful student in Edinburgh. He spent a total of ten years at university and won many academic prizes. I am sure nepotism must have played a part in my selection as a medical student. However, my achievements seemed to hold less relevance to me. I decided very early on that any mark over 50% meant that I had overdone things.

Instead I rapidly became interested in the Scottish Enlightenment. This was a movement that emphasised the fundamental importance of humanity and reason as powerful forces for the benefit of society. It preceded the better known French version by quite a number of years. I also dabbled in trying to understand Surrealism and liked the way that it could appear to free me from logical constraints such as rational and utilitarian values. I liked the rather vague idea that rumination and reflection were the key to a fuller reconciliation between the self, art and life. I read the seminal Sixties "must read" Jack Kerouac book, *On the Road*, and fell in love with America.

In 1966 I did an externship in Tucson, Arizona. I travelled over 10,000 kilometres on Greyhound buses. I loved the way that the bus drivers listed the places we were headed for: Chattanooga, Tuscaloosa, New Orleans, Cincinnati. It seemed like a sort of poetry. A Greyhound bus is a beautiful creation: sleek, smooth and silver. Seeing these machines gliding almost silently along the freeway inspired me and fed my idealistic peregrinations. There's even a whole website devoted to poems about Greyhound buses. Three months in the U.S. finally freed my mind from any traditional thinking that I might have acquired in Edinburgh.

I started reading about Freud as well ... and the way that there was something less than rational about us human beings. Dreams and their analysis enabled us to make sense of the unconscious. When I arrived back in Edinburgh in mid-1967 quite by chance I was on a psychiatric run. I realised that all that stuff I had had time to reflect on was beginning to make sense. I was lucky enough to meet two professors who were world leaders in psychoanalysis. I became star struck with their brilliance and their ability to dissect the sometimes barely intelligible things that patients would say. Cutting to the chase, I decided to become a psychiatrist and to go back to the U.S. I applied for an externship at a psychiatric centre in Ward's Island Hospital, New York – and this was where my enlightenment would occur.

When I arrived in New York I found that Ward's Island "hospital" was really a warehouse for mostly black patients. There was a tight security system to keep all the patients locked up at night. Ward's Island had its own police system. I even had my own set of keys. I could visit patients when I wanted to. The most humorous person I have ever met was in solitary confinement. When I was with him I felt that in another life he could have been a talk show host to match Johnny Carson or Dick Cavett. I later found out that he had cut his wife into inch cubes and put them in his fridge.

Most patients there were on huge doses of phenothiazines. Most of them had Parkinsonian rigidity and moved very slowly with a distant reptilian stare. Everyone was scratching (due to a phenothiazine-induced photosensitivity).

By contrast, on the weekends I used to socialise with my fellow students in Manhattan. They introduced me to their friends and family. These two sets of experiences were like chalk and cheese. No one in Manhattan seemed to have anything wrong with them, as far as I could tell, other than a modest dose of narcissism. This was at a time when psychoanalysis was at its peak. It came as a great surprise to me when I discovered that a number of the students, their friends and their parents were undergoing psychoanalysis at huge expense.

It was time to exercise the lesser known part of the Hippocratic Oath – reflection. I was confused, dazed, impressionable and thousands of miles from home. I had been reading about dreams and their interpretations – but this was one which didn't really make any sense at all. Turmoil, chagrin, doggedness and a sense of pride combined to create a toxic mix in me. I'd invested a lot of time and energy getting to this point. This was not the time to quit.

And then I met Woody Guthrie ... well, sort of. Throughout history singers such as [Bob Dylan](#), [Johnny Cash](#), [Bruce Springsteen](#), [Harry Chapin](#), [Pete Seeger](#), [Joe Strummer](#) and [Billy Bragg](#) have all acknowledged him as a major influence. I was introduced to him by seeing his son, Arlo Guthrie, in concert. He was a hugely popular singer in his own right and was also one of the prime movers of the anti- Vietnam War movement. I knew that Woody had stopped performing a few years previously but I didn't know why. He died on October 3, 1967. I read about it in the *New York Times*. He'd become progressively demented from Huntington's disease. He had been locked up in The Creedmore Psychiatric Centre in Queens, New York. I felt I needed to make a "pilgrimage" to just have a look at the place and I was absolutely shocked. It was even worse than Ward's Island. The building was crumbling. I stood outside and felt sad beyond belief. The patient abuse, inhumanity and neglect felt palpable. Later in life I found out that Woody's name was actually Woodrow Wilson Guthrie – he was named after a former U.S. president.

I still feel sad when I recall these events in my life. I'd been young and idealistic. I felt a degree of bitterness that my idealism and sense of purpose had been shattered. Sometimes when the words "a heavy heart" are used, they can sound a bit clichéd. Even after all these years these are the words that come to mind when I recall these events.

The words of the old song say "Pick yourself up, take a deep breath, dust yourself off, and start all over again". And in the end that's what I did. At the time I'm not sure that I had fully figured out Woody's role in helping me to walk away from psychiatry, but looking back it seems clear to me now.

Later in life I came across Louis Pasteur's memorable quote, "Chance favours the prepared mind". All this frantic self-examination can, I suppose, be summarised with these few words in mind.

Oddly enough, in 1968 I returned to the U.S. for my internship at King's County Hospital, Brooklyn, New York. Here I met two amazing role models, both renal physicians. They were great teachers and they magically demystified fluid and electrolyte balance for me. I have to admit to a certain amount of pride when my colleagues would approach me to discuss

acidosis and hyperosmolar coma. Being a doctor is indeed a happy home for an immensely wide spectrum of folk.

Jill McIlraith

Miraculous Maisie

By Jill McIlraith -
June 27, 2016



As a child, Jill McIlraith wanted to be a vet (or a policewoman) but settled for being a human doctor instead – and has never regretted it although animals continue to be pivotal to her life.

Miraculous Maisie

In the realm of angels and miracles, a schnoodle is an unlikely heroine.

But making grief bearable, helping a 68 year old lady fall in love again and bringing a family together is all in a day's work for Maisie, a schnauzer-poodle bundle of cuddles and energy.

A few colleagues tease me (others just think it slightly odd) that I remember the names of my patients' dogs and cats more often than I do their children's. Asking about their pets has become part of the therapeutic bond I share as a general practitioner with many of my patients. Many, of course, are not animal people and we then move onto other areas of mutual interest on which to build the foundation of continuity and confidence essential for successful doctor-patient interactions.

But talking about other touch-stones of Kiwi life such as rugby and favourite Super 12 teams, politician's eccentricities and changing the flag and the weather just doesn't arouse the same warmth that sharing pet stories does.

In medicine, you have to take joy where you find it: you need good days to balance out those when you tell someone they have cancer, or that they are not going to get their knee or hip replacement because they don't meet the local DHB's threshold.

So I revel in those occasions when a patient pulls out a photo of their dogs or cat – their face lights up, their voice lifts and their spirits soar, all of which is much more successful at lessening their ills than my pharmacopeia.

Pets are a focus for their caring and provide a consistency to daily life against which we can weigh the uncertainty of being sick or just getting older. Some patients have brought their dogs to our practice to be introduced, to the slight disapproval of some staff that think dogs shouldn't darken the doors of a medical centre.

But what doggy patients and I both know, deep down in our souls, is that dogs are often more important to healing than the tests I order, examinations I do or pills I hand out. They know that it is huge source of comfort to stroke a dog's head and feel a cat purr and don't care that science has backed this up as lowered blood pressure and heart rate.

Maisie epitomizes this. When her owner, Glenna (I use her name with her consent), lost her husband to cancer, she was devastated –the house was empty and cold and she found herself staying late at work to avoid going home. Her family, although all close by, were busy with their own lives. Days were long and lonely and her world contracted around her.

Talking about grief and coping strategies, I suggested that she consider getting a dog. Above my desk is a favourite photo of my daughter with Archie and Boris, our Cairn terriers, all three looking alert and ready to tackle the world. The picture is often a talking point for patients – children, especially, want to know the dogs' names and whether they are naughty.

I talked to Glenna about how dogs put the world into perspective and are an antidote to angst and sadness; how they take us out of ourselves and reconnect us with the world. She was dubious but said she would talk to her family about it.

She had never been a dog person, so it was a shock when a small black bundle of soft fur and liveliness arrived and she was instantly smitten.

"I thought I was too old to fall in love with a puppy, but she has been like a miracle. To have this little breathing creature greet me each day the way she does – rolling over on her back with all four paws in the air – before cuddling up, has been just the most wonderful thing."

"She has filled the house with energy, life and love. It has been a journey of discovery that has taken me by surprise. I share my ups and downs with her and talk to her all the time."

Glenna says that she would never have anticipated that she could fall so hopelessly in love with a dog.

“I always thought people who were nutty about their dogs were slightly odd. But now I get it – you *can* become besotted with a dog. I can see how they become a central part of one’s life. Maisie has been life changing. She has been a guardian angel to me.”

And Glenna says that Maisie has been wonderful for her whole family and has brought them closer together. Doggie members of her family shared her upbringing, offering advice about where Maisie should sleep, how to toilet train her and how to get the balance right between loving her so much, and not letting her become the boss.

It has also had a direct therapeutic benefit for Glenna: she exercises more, as Maisie doesn’t care if it is sunny or if the southerly is howling through Dunedin’s hills. She is always thrilled and ready to go walking and to fill each day with delightful exuberance.

Many of my patients know that I like animals and have a menagerie including pet goats and an elderly ewe called Lambchops, who shall never be asked to fulfill her named destiny. Most also know that I continue to love them even when the human-animal interface is challenged, as happened when my horse Larry bucked me off and broke my pelvis and five vertebrae.

Larry has now been retired from being ridden – declared too unpredictable by the local horse whisperer after nine months of attempted rehabilitation. But he remains part of the family, living up to his name by happily chomping his way through knee-high grass as a paddock mate to Harriet. He still has a place in my heart.

Animals are often an integral part of patients’ stories and all the odd things that happen. I am often astounded at how complex ordinary lives can be and how animals are interwoven into our narratives.

One patient recounted to me all the dogs she had had, remembering all their names and quirks as she has loved and lost them, like steps on the ladder of life of her long life.

Animals impact directly on the well-being of many of us – what can be sadder than having to say goodbye to a dog who has loved you unconditionally for years and doesn’t understand that frailty has meant that a rest home now beckons? Or the urgency felt by one elderly lady who insisted on leaving hospital as soon as possible because she was worried her cat was lonely?

Ripples from such sadness can manifest in a myriad of ways from depression to chest pain, just as the joy of loving a pet can mitigate such symptoms. Another of my patients has a tiny Chihuahua, Teddy, who is so small he sits comfortably in one hand. But he has been enough of a force to counterbalance her significant congenital medical problems and a very dysfunctional family. Teddy, of course, is oblivious to his pivotal role he plays in this young woman’s life.

A patient recently told me her favourite story of how dogs came to play such an important part in the lives of humans: When Adam and Eve were kicked out of the Garden of Eden and the gap between Heaven and Earth grew wider and wider, at the last moment a dog leapt across the chasm. This was so humans would know the benefits of unconditional love and the joy that everyday dogs bring to everyday lives.

As doctors, we try to help patients interpret what is happening to them and be there on their journeys. Sometimes we underestimate the impact of advice we offer and not all my well-meaning suggestions to patients have been as successful as Maisie.

It is the only time I have suggested a patient consider getting a dog – usually I would be wary of asking anyone to make such a commitment and am very against live animals as presents. But the bond that has formed between Glenna and Maisie has been more successful at helping her cope with life and loss than anything else I have done.

Maisie, of course, is blissfully unaware that she is a heroine – she is too busy doing her doggy thing of living and loving in the present.

John Berger, in ***A Fortunate Man***, his famous essay about being a country doctor, stresses that a vital element of being a good doctor is the ability to identify with patients, to form a fraternal bond (1). What patients often need, is not more medicine or hospital, but “more doctor” – it is the personal interaction and connectedness that is integral to the healing process.

For some patients what may be most beneficial for them is “more dog”. What could be more miraculous than a gift as small as a five kilogram schnoodle that keeps on healing?

(1) John Berger: ***A Fortunate Man***. Penguin Press, 1981.

Jane Miller

Sanibona – I See You

By Jane Millar -
November 30, 2017



Working as a doctor in South Africa there is more joy than sadness and more successes than defeats. But human nature's downfall is to dwell on the struggles. Rather than letting these negative thoughts fester, I have composed a memoir ... the process has been liberating.

Sanibona – I See You

South Africa has many divides, rifts between cultures, gaps between the haves and have-nots. It is easy to ignore the destitution while enjoying a lavish lifestyle enclosed by high fences. Here, when your car gets stolen (again), my affluent friends coin it "Third World Tax"; the regular compulsory payments necessary to live in luxury surrounded by perpetual poverty.

But inside the crumbling walls of the government hospitals you can ignore it no longer. Misery and anguish are in your face, in your arms and forever on your mind.

Before embarking on my work in South Africa I knew the facts.

High child mortality rate, rampant HIV, extensively drug-resistant TB – all with insufficient resources to tackle their enormity.

Now I know the faces.

The faces of the mothers and children have been etched in my memory with my guilt and profound sadness. I feel their pain and every day they stare into my mind's eye.

A few faces in particular have stuck in my mind.

One was a newborn baby. The intern wheeled the incubator from the delivery room into the sweltering nursery, a sea of cots, swerving around the buckets filled with dirty rain water dripping through the ceiling. The baby, a nameless boy was flopped onto the Resuscitaire. He was ashen and gasping, his eyes wide and staring. Yet another birth asphyxiation. The neonatal department was bulging at the seams; it didn't have the resources to help babies with such poor prognosis.

I dreaded these cases. I felt helpless for not being able to give the simple yet life-saving breathing support and brain cooling I know is readily available back home in New Zealand. I then felt guilty for actually wishing this baby, someone's child, would die.

T.I.A – This Is Africa. Survival of the fittest. If this baby survived it would be grievously neurologically impaired. The paediatric wards were full of children with severe cerebral palsy – malnourished, neglected and suffering. One child at 10 years old, who was unable to feed himself, was an emaciated 5 kg. I can still vividly recall trying to cannulate his seemingly mummified arm. I didn't want that to happen to this baby but the irreversible hypoxia had already occurred. Therefore, if I didn't want him to suffer anymore that meant dying.

My orders to the intern? "Comfort cares." How ironic. Nothing was comfortable about watching that child, eyes staring wider and wider, choking on blood as it fountained from his nose and mouth from a pulmonary haemorrhage. I suctioned the airway and wiped the splattered blood up my arms on my scrubs, prescribed the vitamin K and moved on to the next baby on the infinite conveyor belt of the South African healthcare system. When I looked up, I saw the intern crying. I shrugged at her to tell her she'd get used to it.

But I knew she wouldn't, just as I never did. I was just weakly putting on a brave face to help her get through her 30-hour shift. The reality was, I wanted to cry too.

For every child that died in my care, their memory has stuck with me. I can recall every feature from their faces to their fingernails and their mothers' wails are still resounding in my ears. To this day can I feel those asphyxiated babies' wide startled eyes still watching me.

The paediatric malnutrition unit was heated to keep the fragile meagre beings warm. The heat intensified the already stifling feelings of guilt and shame for the neglect, poverty and HIV that brought those mothers and children together in the unit. It was too much for one young mother, who attempted to smuggle her stick-figured child out the door hidden under a chip packet in a plastic shopping bag. Most children admitted were wasted to minute waifs with rotund swollen bellies. Nearly unanimously riddled with HIV and TB, their give-away sign was their matching orange (rifampicin) vomit stains down the front of their grubby hospital gowns.

The rest of the children had kwashiorkor, our "kwash babies". A fittingly descriptive word, "kwash" – almost onomatopoeic for their oedematous, seepy skin. The worst kwash baby was a 15-month-old twin. The runt of the family, neglected to be fed enough and tipped over the edge and into hospital with a diarrhoeal illness. Children with severe acute malnutrition don't qualify for high dependency or intensive care because of their abysmal

prognoses. Sepsis set in and as this child's albumin near vanished she blew up like a water balloon.

In South Africa the majority of doctors give up slaving in a broken Government healthcare system to go and work in private hospitals once they've gained enough experience, and you can't blame them. In doing so, they abandon the junior consultants, who in general are great at keeping children alive, but not so good at knowing when to let them die. We had done everything possible for this kwash baby, to no avail. It was time to let go. The frequent blood gas measurements were pointless because they weren't changing our management. Yet in the middle of the night, as instructed, I found myself taking blood from this baby. I leaned over the mother, who was sleeping on a plastic chair with her head in her arms on the bed. As I shined my cellphone torch over the bed cockroaches skittered over the child, whose eyes were swollen tightly shut. From experience I already knew that attempting to take blood from the child's hands, feet or scalp just resulted in serous fluid, so I poured chlorhexidine over the groin area. As I wiped the skin with cotton wool it just peeled away. Dressing packs were a long-forgotten luxury; instead I used my sterile glove packet to create a semi-sterile field. The needle pierced the skin and went into the femoral vein and the baby didn't even flinch. As I was doing this, possibly because I was hour 20 on the job, I had an out-of-body experience where I was watching myself perform the procedure. The whole scene was grotesque. What was I doing? What was the point in this? How could a simple lack of food result in such torture? The eyes I never saw, but that baby's swollen, cockroach-riddled face is unforgettable.

On the general paediatric ward, things weren't any less grim. I was looking after a child suffering from HIV enteropathy and disseminated TB – with subsequent pancytopenia and a urinary tract infection with carbapenem-resistant enterococcus. In summary, all bad news. For weeks I had been looking after her – daily examinations, blood tests and futile fiddling with medications. One day, as I went to examine the child, her scrawny hand grabbed mine, her long dirty finger nails dug into my skin and she looked at me with a look of fury. She didn't say anything but her eyes fixed on mine. This was her way of saying stop. And for a moment I did. I held onto her skeletal hand with tears in my eyes. I wanted to hug her and say I was sorry, sorry that there was no palliative care, sorry that the struggling health system had failed her. Mother-to-child transmission of HIV is completely preventable, HIV progressing to AIDS also. At 4 years old, she should be outside in the African sunshine playing with her friends; instead she weighed less than an average 1 year old, was bed-ridden and sitting in her own blood and excrement.

My consultants talk about today being the “era of effective prevention of mother-to-child transmission (PMTCT) of HIV” and that now is nothing like the dark days of the epidemic in the early 2000s with no available anti-retroviral therapy. Me, I disagree. To call this PMTCT programme effective is to ignore this dying child and the other hundred infected each month. Yes, the programme has improved, but it has huge holes that only the most vulnerable children in society fall through.

A week later, in the child's last hours, an exemption was made with the security team and some of the extended family members were allowed to visit. Before they arrived, the mother took me aside and told me not to mention the HIV diagnosis in fear of shame. I agreed but I was upset.

I believe this is where the problem with HIV in South Africa lies. If you look in a patient's file it will say “RVD (retro-viral disease) positive”, “exposed” “PCR positive” or “rapid test

positive” – but nowhere will you find the word “HIV”. An HIV test is a VCT (voluntary testing and counselling), and the HIV clinics are named something sickly sweet like “Good Health Clinic” or “Hope of the People”. The first time I prescribed nevirapine I wrote “HIV exposed” in the space on the chart for clinical indication. I was later taken aside by the Head Matron and told off for writing something so incriminating on a chart. With an HIV sero-prevalence of 40% in the district, it is nearly as common to have HIV as it is to be *female*. Yet as a medical professional, treating the disease we still had to tiptoe around it, further perpetuating the stigma. If we as doctors don’t say it out loud – “H I V”, then how can we expect it to be accepted in the communities as just another chronic illness, not a death sentence and definitely nothing to be ashamed of? The mother of this dying child most likely avoided testing during pregnancy, then probably didn’t attend clinic appointments or give her child medications in fear of the shameful diagnosis being revealed.

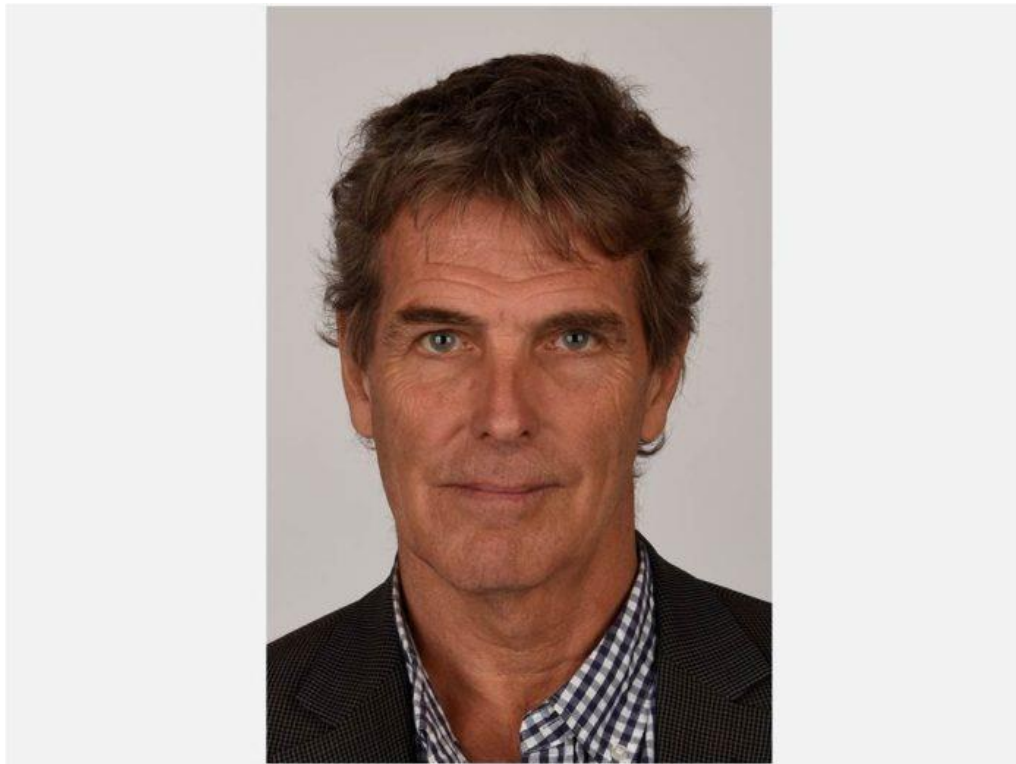
A PMTCT programme isn’t effective until paediatric HIV is over, and the programme won’t be effective until we talk about HIV openly. I channel the anger in the eyes of that child dying of AIDS every day. It motivates me to fight harder for the health of children, and not just children in Africa.

To all the South African children I care for, sanibona manje – I see you always.

Paul Reeve

Doctors' Hours and The Mess Dinner

By Paul Reeve -
November 21, 2016



Doctors' Hours and The Mess Dinner

"Things were different in my day" is an expression every junior doctor hears from at least one of their consultants, especially the older ones. That is one *"thing"* that actually doesn't change. My juniors will all have heard me say something similar, probably more than once. I try not to but sometimes I can't help myself and it just comes out.

It was a long standing tradition at my teaching hospital, Bart's (the Royal and Ancient Hospital of Saint Bartholomew's), that a mess dinner was held at the end of the six-month house officer runs in July and January. It always took place in the Great Hall. It was very formal; dinner suits and long dresses were the expected attire. We had a sit down meal with waiter service and lots (and lots) of wine.

The Great Hall is an imposing venue. The building dates from the 18th century. The Baroque style hall has a high ornamental ceiling; the walls are crowded with plaques listing the names of the hospital's benefactors. The sums each donated are shown; some are odd totals because they came from the remnants of deceased estates.

There was some artwork, many of famous past Bart's men, but the most impressive paintings were murals by William Hogarth (1697-1764) which greet you as you ascend the stairs. They depict biblical scenes: The Pool of Bethesda and The Good Samaritan.

Apparently Hogarth offered to paint them for free when he found out an Italian artist might be commissioned to do the job. He was rewarded with a ward being named after him, one of few dedicated to non-Bart's men. Hogarth was a Freemason so may well have had another connection with the hospital. Several (possibly most) of the surgeons at Bart's "*in my day*" were supposed to be Freemasons.

It was a tradition to invite the most recently appointed and the most near to retiring consultants to give talks. There were four consultants at my mess dinner in July 1982.

Their speeches were reminiscent of the famous Monty Python "*Shoebox*" sketch, also known as the "*Four Yorkshiremen*". If you haven't seen it there is a video on YouTube. In the skit four well-dressed men talk about their humble beginnings and difficult childhoods. It is a parody of nostalgic conversations as they try and outdo each other with accounts of their deprivations, which rapidly become more and more absurd.

"Well of course we had it tough... we used to get up out of shoebox at twelve o'clock at night and lick road clean with tongue."

The Yorkshire accents get progressively stronger. Those aren't grammatical mistakes.

It ends with: *"...and if you tell that to young people today, they won't believe you..."*

All the Yorkshireman then say together *"No – no they won't!"*

It has been described as the best Python sketch and was a regular in their live shows. Interestingly, Graham Chapman's funeral (he was a Bart's graduate and co-wrote it) was held in the Great Hall. He would have laughed about the events of that night.

Junior doctors' hours have always been an issue. The guest consultants made that the subject of their speeches. I don't think it was planned or coordinated; it may have been, but I don't think they would have been that subtle.

The first two consultants to speak, the most recent appointees, told of getting a weekend off a month while pointing out that we "*only*" had to work every other weekend.

Can you picture the scene? The speeches were after dinner (and a lot of drinks) and the heckling soon started. The audience of house officers was getting restless.

The first of the retiring consultants then rose to his feet and claimed that he had worked all 365 days of his year as a house surgeon, he had no time off at all and he had to ask permission to leave the hospital grounds: *"... and not only that... we didn't get paid..."*

By this time the parallels with the Monty Python sketch were apparent, if unintentional. How could the last consultant beat that? The crowd was restless. Paper napkins were torn up and dipped in water (and then wine) and the top table was bombarded.

The last old boy confirmed everything his younger colleagues had said and finally finished with: *"...and we were expected to contribute to the cost of the patient Christmas turkey."*

I suspect the top table complained to each other after the dinner, not much differently from Python's four Yorkshireman: *"...and if you tell that to young doctors today, they won't believe you..."*

Working In Vanuatu: Politics and Medicine

By Paul Reeve -
December 5, 2017



“By three methods we may learn wisdom: first, by reflection, which is noblest; second, by imitation, which is easiest; and third by experience, which is the bitterest” is a saying attributed to Confucius. One of our trainees recently started a talk with it. She had asked if she could use some of my slides. I have taken the liberty of using her quote. Anecdotal experience is the greatest driver of practice. As I have aged I have reflected more and more on my own experiences. As a doctor one has the privilege of looking after some fascinating people and I like to think I have learned from them.

Working In Vanuatu: Politics and Medicine

You couldn't invent a more exotic place than Vanuatu; a novelist or scriptwriter who did would have audiences questioning their credibility. Could a country of active volcanic islands surrounded by shark-infested waters and subject to devastating cyclones really be home to the happiest, if some of the poorest, people in the world?

Who would create a land populated by people speaking over a hundred different languages who, within living memory, were animist cannibals; whose grandparents had eaten the first missionaries but who were now devout Christians? A country where the men celebrated the legend of an adulterous wife tricking her husband into killing himself, by leaping off tall towers with vines strapped to their ankles, and so inspired the craze of bungy jumping?

What fictional country ever had a colonial history of rule by the French and the British, both at the same time? Many territories have had successive colonial powers, but where else did the French and British share power for the best part of a century? When did those two traditional enemies ever agree on anything? Who would ever make that up?

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Throw in a coconut rebellion financed by right-wing investors, an unstable and often corrupt government, off-shore tax haven status, flags of convenience, shady Asian businessmen and dodgy expatriates and you could have the setting for a Bond film.

One of the starring roles would have been Jimmy Stevens, the government's public enemy number one. I first met Jimmy when he arrived in Outpatients with a prison guard to have his blood pressure checked. Despite multiple drugs, his blood pressure remained uncontrolled and I admitted him. I never got around to discharging Jimmy back to prison; he was to stay in hospital until his eventual pardon on the 10th anniversary of independence two years later.

Jimmy had been the leader of the so-called "Coconut Rebellion" in the New Hebrides nearly 10 years earlier. He was quite a character; with his long grey hair and beard he resembled an Old Testament prophet; he usually wore just a wrap around his waist.

Jimmy had entered politics pushing the cause of a group of bush people who were protesting at the clearance of their kastom land for cattle ranching. Through multiple marriages (to an estimated 31 wives from different villages and islands) and the foundation of his own church he was able to extend his influence throughout the country. Under his charismatic leadership he went on to take Santo to the verge of independence as a separate island state.

Unfortunately he fell under the influence of manipulative French planters and American investors; an ill-fated attempt at secession led to his arrest and he was imprisoned when all the other leaders were celebrating the independence of Vanuatu.

At Jimmy's trial, it was revealed that he had received USD \$250,000 from the American-based Phoenix group, which had previously attempted to establish an independent tax-haven state in the Bahamas. He was convicted and sentenced to 14 years in prison.

Jimmy had little formal education but he had imagination and a memorable presence and he was still well-respected despite his conviction. He was generally acknowledged to have healing powers of his own and was often consulted by my patients and their relatives. He did his own ward rounds after mine.

Jimmy's length of stay was not quite a record for me; I had a longer-staying patient in rural New Zealand (a sad case of a young woman with severe brain injury following a Caesarean section), but Jimmy's was the most prolonged admission of someone I could have discharged, albeit if only to go back to prison.

Jimmy ended up babysitting my children one weekend. My Saturday morning ward round had gone on longer than expected and my wife, Elizabeth, appeared with the children; she was due to start her half-hour stint hand-ventilating a baby in the nursery.

The Vila Central Hospital medical superintendent's secretary had delivered a premature girl the week before. Breathing problems developed and because of the mother's very poor obstetric history our new paediatrician had decided to attempt ventilation. With no mechanical ventilator available, a group of expatriate ladies were taking turns at bagging the baby. It was Elizabeth's shift; someone had to look after the children and Jimmy volunteered, or at least he agreed to when I asked him.

I collected the children, Clare and John, from my office just as Jimmy finished relating his own version of the Coconut Rebellion; he was in the middle of telling them how one of his adult children had been shot. His son was the only fatality of the independence struggle in Vanuatu.

My experience with Jimmy wasn't the only time medicine got mixed up with politics. I was the only physician in Vanuatu, then a country of about 200,000 people. In my four years there I treated the Prime Minister, the President and the Chief of Chiefs. It wasn't always straightforward.

A couple of days after the Prime Minister was admitted with a heart attack, a senior nurse came to see me and said: "It might not be a bad thing if the Prime Minister doesn't survive", the implication being that I might be able to influence the outcome. I was shocked, but only briefly. The nurse belonged to a very political family that was at odds with the PM's own faction of the ruling party. There had been a split within the party and the nurse's brother, who had been a minister, was challenging for the leadership.

Needless to say I didn't do anything to change his prognosis. The PM had a small and uncomplicated myocardial infarction. I did stay home over the weekend so that I was readily available had there been a problem. After five days the PM was discharged and flew out to Australia for further tests.

Expatriates and senior government officials sometimes tried to bypass the hospital and see me directly, so I tried not to be too available. Elizabeth got very good at fielding phone calls. Theoretically I was always on call, but only if I could be contacted by the hospital. Any caller had to go through the hospital switchboard; if connected to me, they then had to deal with Elizabeth.

One evening there was a call from a patient's wife. Elizabeth diplomatically suggested she follow the normal process and that she should try the hospital, but the caller was insistent that her husband was "my patient" and she needed to talk to me. Again, Elizabeth made the point that I only saw patients that the hospital staff could not handle.

The caller was politely persistent. Elizabeth realised that there was something more to it and asked to whom she was talking; it was the President's wife. I had been treating him for chronic myeloid leukaemia. The phone was passed over to me.

I quickly established that the President had collapsed at home. I drove straight round to the Presidential residence. The President was lying on the floor of his private nakamal (kava-bar); he was semiconscious but responding to painful stimuli. On the Glasgow coma scale he would have rated a 7/15: he was withdrawing to pain, his best verbal response was a grunt but his eyes remained closed. He was moving all four limbs; at least it didn't look like a stroke, despite his vascular risk factors.

It is always a good idea to take a history first: I quickly established that the President had been drinking kava and mixing it with beer; it wasn't a good combination, but at least it explained his state. I helped his *aide de camp* get him to bed. His wife was very grateful, if a little embarrassed. We never talked about it again, but when I left Vanuatu the family were invited around for tea and I was presented with a wooden carving.

I also treated the most senior chief in Vanuatu, the “Chief of Chiefs”, who developed heart failure. A big man, literally and metaphorically. He actually did well and was the longest lived of the three top men, surviving until he was 69. The President died at 59 and the Prime Minister at 56 or 57, his exact date of birth never having been recorded. Power and affluence aren’t necessarily good for your health.

Jimmy Stevens was in hospital during all these admissions; I am not sure that he actually visited any of his political opponents.

When it came to the 10 year Independence Anniversary, Jimmy’s release, along with a number of other prisoners, was being considered as part of the celebrations. I had to present myself to the PM’s office and answer whether Jimmy would be able to be discharged if he was freed. I bluffed my way through a response but nobody seemed to question the coincidental timing of Jimmy’s cure and the amnesty.

After he went home I saw Jimmy again on a visit to Santo in 1992; he was accompanied by two new and very young wives; he smiled knowingly at my congratulations. Sadly, Jimmy never enjoyed good health after his discharge and he died shortly after that. Jimmy’s obituaries make interesting reading but they never did mention his prolonged hospital stay.

As a post-script, another of Jimmy’s sons achieved fame (or notoriety) after surviving the sinking of a fishing boat. Several days after the boat had disappeared he turned up in Noumea, the sole survivor of the shipwreck, suffering from exposure but alive. He maintained he had been rescued by a large manta-ray which carried him to shore.

Surprisingly, or maybe not in Vanuatu, his story, laughed at by the expatriates, was accepted by most locals. Melanesian and Polynesian mythology is full of stories of men traveling on the backs of sea creatures.

What happened to the ventilated baby?

She survived and was named Victoria after the paediatrician’s daughter.

Obstetrics in Africa

By Paul Reeve -
February 19, 2018



Obstetrics in Africa

Unfortunately Western textbooks are not always very useful when it comes to managing childbirth in Africa. I will never forget my first (and only) hysterectomy in 1983.

The mother had presented with a prolapsed hand. There was nothing too unusual about that, except that the baby was dead, the hand had been out for two days and the mother had been taking traditional treatments – which were potent uterine stimulants.

What to do wasn't something I could look up in a textbook. In the First World women don't present several days into labour with a dead baby. We had to go back to basics. After that length of time uterine infection was likely and a Caesarean section was to be avoided but the cervix had clamped down on the arm and a destructive procedure was going to be difficult. We made a decision to attempt to extract the baby under a light general anaesthetic. Halothane, we knew, was a uterine relaxant. We were only a couple of years out of medical school and we didn't realise how much we didn't know.

I began the procedure as the anaesthetist and ended up as the surgeon. Elizabeth, my wife, began as the scrub nurse assistant and ended up as the anaesthetist. Brian, a colleague with a year's more experience than me, began as the surgeon and ended up collapsed on the floor.

While working at Jane Furse Hospital, an ex-mission hospital in rural South Africa, I had spent a few weeks on the maternity wards so I could go on the obstetric roster. That meant doing Caesarean sections when the midwives said it was necessary. Cephalopelvic disproportion (CPD) was common in the local women. Nutrition had improved so babies were bigger than their mother's pelvic outlets. The midwives were very experienced at making the call. The previous medical superintendent had even trained one of the theatre sisters to do most of the Caesareans herself. He would turn up just in time to incise the uterus, extract the baby and leave her to sew up afterwards.

I still maintain a Caesarean was the easiest laparotomy to do. At least you knew you were facing a pregnant uterus. With a suspected appendicitis you're never sure until you find it. We did them under local anaesthesia with a mid-line incision through the abdominal wall which made it easier. I ended up doing over 60 procedures.

There was a tradition at Jane Furse that if you did the Caesarean you got to name the baby. We used to have a theme each month – naming children after flowers, medications or whatever. Previous doctors clearly had a sense of humour. There were children named after engine parts and a cohort of one year olds, born during the Falkland's war a year earlier, with names like 'Malvinas' and 'Belgrano'.

But back to the case; after attempts to remove the dead baby, we had to give up and operate. It was immediately apparent the uterus had ruptured. The dead baby was outside the uterus and the abdomen was full of blood. It didn't look good.

Poor Brian, the nominal obstetrician, blamed himself and asked me to take over. Elizabeth clamped the jagged and bleeding edges of the rupture and then took over the anaesthetic. Her shouts to Brian to pull himself together had fallen on deaf ears. I quickly scrubbed and gowned up and became the surgeon.

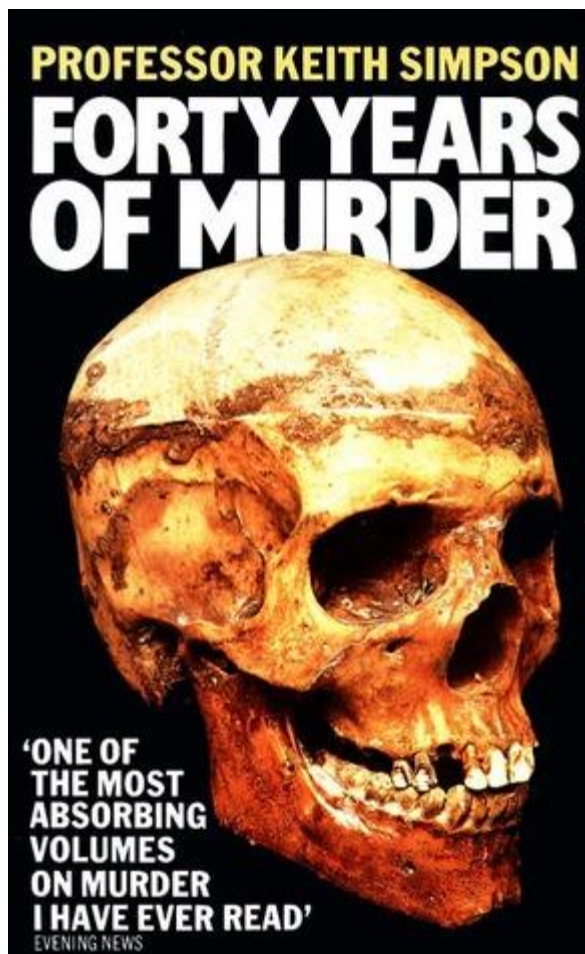
It was a mess. In anatomy textbooks, the various organ systems are all different colours; arteries are red, veins blue, nerves black, muscles brown, the bladder yellow. In real life everything is red or turns red very quickly. It was very red.

A pool of blood kept refilling the pelvis as fast as we could suction it out. I extended the rupture to a sub-total hysterectomy and removed the uterus but left the cervix. I cobbled what remained together.

Brian's contribution was to keep insisting I shouldn't cut the ureters. I responded that I couldn't see the bloody things. Eventually the poor woman stopped bleeding. She survived ... and passed urine the next day.

A Post Mortem with Sir Keith Simpson

By Paul Reeve -
February 19, 2018



A Post Mortem with Sir Keith Simpson

'These patients with heart disease don't do very well with surgery do they,' said Professor Sir Keith Simpson. He was taking me through the dissection of the patient's heart. It was a coroner's case. He was the coroner. The deceased had been my patient.

I felt guilty that her death might have been the result of a mistake I made in not prescribing her usual medications on the morning she had surgery. I had beaten myself up about it for several days but in the end it wasn't relevant. Her death wasn't my fault.

The deceased was a sixty year-old woman. She had been admitted for a mastectomy for breast cancer. She had rheumatic heart disease with atrial fibrillation and was on warfarin, an anticoagulant, because of the high risk of blood clots and a stroke.

I had checked on her potential for bleeding with the surgical senior registrar. He was insulted that I would question him about it, the implication being that his surgical technique couldn't cope with her blood being a little on the thin side from her anticoagulation. I didn't ask about her other therapy. In those days nil by mouth meant just that and we usually withheld all tablets on the morning of surgery.

She became breathless 12 hours postoperatively. I was called to see her. She was puffed but in no distress. Her heart rate was up at around 120 and her blood pressure on the low side at 100/60. Her venous pressure was not elevated and her chest was clear meaning there

were no signs, at least clinically, that she was in heart failure. There was no evidence that she had bled significantly and the drains in the wounds were near dry.

Her electrocardiogram showed fast atrial fibrillation but no new changes. Her chest radiograph demonstrated a big heart, which was unchanged, with no signs of fluid in the lungs or of congestion of her veins. That meant there was no radiological evidence of failure. I was at a loss for a diagnosis but she had not had her usual treatment of digoxin or frusemide so I charted them.

I was concerned that I might be missing something and worried all night. When I say '*all night*', I mean that I ended up with a restless sleep and woke up a couple of times thinking about her. Most doctors will know what I mean.

I got up to see her very early the next day. She was much the same. I spoke to the surgical senior registrar who just said, '*Get a cardiologist*'. I bleeped the duty registrar.

I had a couple of jobs to do and wasn't on the ward when the cardiology senior registrar arrived and examined her. He had just finished looking at the chest X-ray when I got back.

'She has heart failure ... you're mismanaging the case,' he told me. I tried to explain that I didn't think the X-ray had shown any evidence of failure but I was just a first year junior and he was a very senior registrar. He wouldn't listen, dismissed me and left the ward.

The patient was taken to the coronary care unit, put on an inotropic agent and given diuretics. She didn't respond and got worse. She remained hypotensive and her urine output deteriorated.

She then developed abdominal pain and swelling so it became clear that it wasn't just her heart that was the problem. She was taken back to the operating theatre and had a bowel resection for ischaemia.

She had also bled into her chest wall. A big haematoma was drained. Blood loss had been the explanation for her fast heart rate and low blood pressure. The diuretics she was given for the incorrect diagnosis of heart failure would have made it even worse.

Unfortunately she continued to deteriorate and died. A death after surgery meant it became a coroner's case. I was delegated to be the team's sole representative at the post mortem. It was expected that one of the doctors attended.

I went back and took a look at the notes. The cardiology registrar had crossed out his initial diagnosis of heart failure. He had written, '*I was shown the wrong X-ray,*' suggesting that it was someone else's fault. The obvious culprit was me. I was furious.

As every medical student learns, you are expected to check that the X-rays you look at are for the patient you think they belong to and that the date is right. The cardiology registrar was trying to cover up for his mistake. It was even worse because he had ignored my protests about his diagnosis and his interpretation of the X-ray.

Even more worrying was I found out the coroner's pathologist was Professor Sir Keith (Cedric) Simpson. I was mortified. I had just read his popular book, '*Forty Years of Murder,*' in which he recounted his experience as a Home Office pathologist. Simpson had been

knighted for his expertise. He was then near the end of his career but was still head of department at Guy's Hospital and a coroner's pathologist.

In 1965 Simpson had identified the first '*battered baby*' death but the case I had been most impressed with was of John Haigh, the '*acid-bath*' murderer. John George Haigh (1909 - 1949) was a serial killer. He was convicted of the murder of six people, although he later claimed there were nine. He had dissolved their bodies in sulphuric acid, and forged papers to sell their possessions. Haigh thought he would get away with it because he believed there needed to be a body for a murder charge. Simpson's investigation of sludge at Haigh's workshop revealed three gallstones. It was the key evidence that led to a conviction and Simpson's evidence sent him to the gallows.

What would he uncover in this investigation? What would he do to me?

The Professor was a real gentleman. He asked me to assist with the post mortem and I had gowned up. He found evidence of very severe mitral stenosis. After his comment I relaxed. I hoped that the mask hid my expression of relief.

I got off without any criticism. The cardiology senior registrar went on to better things and became a London teaching hospital consultant and co-authored a textbook.

My decision not to stay on in London was partly influenced by the experience. I left for Africa and a peripatetic career that has taken me around the globe.

Anja Werno

On the Other Side

By [Anja Werno](#) -
August 22, 2016



The story relates back to my time as a patient in a German University hospital in 1990 after a significant head injury. The accident happened whilst working on my MD in the University virology laboratory. A probable “pain syncope” with loss of consciousness resulted my head hitting the concrete floor. The impact caused an occipital fracture and several frontal contrecoup bleeds. Needless to say it was the start of a frustrating, but ultimately lucky, journey.

On the Other Side

Day Zero

That was the start of it. Running around like a demented ape. I have to get the experiment started before the scientists get going. Only another 30 minutes left. I’m not going to make it. Not at this rate. I’m slow today. Too much red wine last night. Aldi stuff, cheap and potent. I can’t imagine being a student without Aldi. Basically, I wouldn’t have the money to stay alive. Exaggeration!

Regardless, I turned up to work. With coffee on board. Lots of it. No food, just coffee. Who needs food? I’m walking along the corridor at a brisk pace, my ELISA plate in hand. Need to get to the plate washer. Not much further. Except, I run my elbow straight into the corner of a wall. It stuck out, damn thing. It hurts like hell, I struck the ulnar nerve. The pain is severe, but I just keep going. Along the lab corridor to begin the next step in the experiment ...

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Still Day Zero

My eyelids flicker, a guardian angel smiles at me. Or is it a nurse? I can discern a blue uniform and the empathic smile that occasionally comes with it. I'm in luck, I can see empathy.

Someone holds a kidney dish next to my mouth. I gratefully aim for the dish and deposit the contents of my stomach into it. Drool runs down my chin. The turmoil in my stomach settles for an instant only to churn more powerfully a minute later. What's happened to me? Where am I? Why do I have an empathic nurse collecting my vomit – a mixture of bile and coffee?

I'm in motion now without moving my legs. It feels like I'm being wheeled around, lying on my back. My head is filled with empty space alongside nebulous recollections of past events. I'm unable to fill all the gaps. Retrograde amnesia. How long has it been?

It dawns on me, suddenly, like a veil lifted to reveal a truth, my truth: I'm on the other side! I'm a patient.

Day One

Lying in bed is bliss. The bed is still. It doesn't rattle my brain. The worst so far has been the travel to and from CT scanners. My traumatised brain feels every tiny vibration of the stretcher rolling across the floor. A lumpy surface translates to major shockwaves through my head, followed by excruciating pain. Feels like blunt knitting needles inside my skull racing to knit a pair of mittens. It hurts so much I could scream my lungs out, but oddly, I can't seem to want to. I'm annoyed, but can't seem to get really annoyed. Where is my temper? I had it the last time I remember being me. Now, I'm feeling pretty relaxed despite the dreadful knitting needles inside my head. Damn it! What's going on? A machine alarms. The sounds gets to me. I wish someone would come and turn it off. Some poor bastard is in trouble, I chuckle silently. I hear voices approaching. One shouts, "She's down to 30. Get the doc!" A face hovers over mine, "Are you alright, love?"

"Yeah," I whisper. I seem to have lost the volume control for my voice. Why wouldn't I be ok?

An age later a man in scrubs leans over me to look at a machine. He takes my right wrist to feel the pulse. A smooth motion and all of it without even glancing at my face. What a slick bastard. He drops the wrist and mumbles to the nurse. Something like, "Normal in head injury ... need to get the pulse up ... could end badly."

Someone is in trouble. Maybe it's Loud Person in the bed next to me, who shouts a tirade of obscenities aimed at someone by the name Karl. Karl must have been a bad one. Someone you wouldn't like, because Karl drank a lot and then he became abusive. Mind you, Loud Person is pretty abusive about Karl. I wish they would stop shouting because it really hurts my head.

I have learned something. When it really hurts badly, I can call out. All I have to shout is “Tramadol” and someone will turn up with a syringe. So, that’s what I do. I shout for Tramadol until some health care slave attends to my urgent wishes. And, it works so well. The pain subsides quickly. I have no idea if it is minutes or hours, but it goes. That’s all that matters. And with the pain disappearing, a feeling of calm fills me. It reminds me of the slogan “Keep calm and carry on”. It’s just like that. The drug works and I carry on. I look at the doctor, who inserts a large bore needle into my vein without so much as blinking. I remember, funnily enough, seeing these horrid things inserted into people’s vasculature whilst on elective as a medical student. At that innocent time I felt sorry for the patients and quite smug for not being in their place. And look at me now. Still, the Tramadol helps. I drift off to sleep wondering when my pulse will drop to 30 next. Will I know? Will I be conscious enough to realise?

Day 10

Yeeha! I have finally made it off the neurology ICU. Discharged onto a “normal” ward. Only drawback, I’m in a six-bedded room. Good news is that only five beds are occupied. Bad news is that one patient is a Recklinghausen’s patient with limited ability to stay quiet. She’s about 40 and all exposed skin looks knotted. I imagine that the knots I see are mirrored in her skull-protected brain, because she is very erratic. I feel for her though. What a life! No one looks after her and she seems lost. She just walks around and occasionally shouts unintelligibly. Eventually, that gets the nurse’s attention. Not much else does. They are understaffed, I hear. That’s unlucky for my bed-fellow, a woman with multiple sclerosis. She hasn’t had a wash in days and her incontinence dampens both her bed and her spirits. I get pretty sick of Madame von Recklinghausen getting all the attention and my friend in the next bed lying in her own excretions. Not much I can do about changing the sheets because I haven’t got any spares, but I have soap and shampoo and water from the tap. I treat her to a soapy wash and a head massage with scented shampoo and conditioner. The newly fragrant world feels better for both of us for just a while. Actually, no. It’s only different for her because I can’t smell anything any longer.

Day 21

The neurological “normal” ward is a thing of the past. I’m now on cardiology, but still unable to smell or taste a thing. No-one but me seems concerned about my total loss of olfactory sensation. They think my heart might be funny. Malignant arrhythmias is today’s speculation. Really? I never had any trouble before. I was just this ordinary medical student who drank too much, smoked too much, studied too much and didn’t have enough of a life beyond focus on the next exam. Heart problems? Not me. So, in comes a nice looking cardiologist to explain that I will have a cardiac catheter. Just a small procedure with only a small risk of a cardiac arrest. But, nothing to worry about, because, really, everything needed to deal with an arrest would be right there. The cardiac catheter would be used to stimulate my “His” bundle – amongst other things. I didn’t think my “His” bundle needed stimulation. In fact, it sounds really unappealing, but I sign the consent form anyway. What else was I to do?

The other two women in the room chuckle. They have had cardiac catheters before. One of them might need another one, because she has a hole in her heart. I don’t think she understands that’s bad news for her. Even after the doc spends half an hour explaining why the hole in her heart needs fixing, she is still not really worried. She quietly confides she didn’t understand a word the doc said, but what a nice man. What a waste of 30 minutes!

The cardiac catheter finds its way to my “His” bundle and I can almost literally feel my heart in my throat. A powerful sensation screaming to my already dodgy brain “something is poking around inside my heart and I might die”. I don’t like it, but eventually it is over and I’m still alive. My “His” bundle is exhausted and if I could scream for Tramadol, I would. Instead, I’m busy worrying about the heavy bag pressing down on my unhappy, pulsating femoral artery. I hear footsteps and I hear a tray rattle down beside me. I open my eyes, see food and smell nothing. Irrationally annoyed, I think “What good is food if you can’t even taste it?” I really don’t feel like eating. I feel like shoving the offensive tray off the table, like ripping the pressure bag off my thigh, like screaming and hammering my fists on the bed in a sobbing, childish tantrum. I wonder again if I could at least swap the tasteless blobs on my plate for some powerful sedative to let me slip into blissful oblivion where I might fantasise about a life resembling normality. My life, before I became a patient, my life as a high-performing medical student, a person with dreams and aspirations. I have been boiled away, condensed, reduced down to an injury, a condition, a syndrome. I’m a non-smelling, or is that tasteless, individual. My only remaining aspirations are not to bleed to death, not to vomit from the recurring dizzy spells and to tentatively wonder what it might be like perhaps, one day, to enjoy the scent of roses again.

Day 30

Nearly there. Approaching discharge. About time or I might start killing people just for a bit of privacy. The smell-thing is troubling me greatly, but now for a different reason. I awoke this morning to find everything around me has the odour of rancid butter. The jury is out on olfactory hallucinations versus recovery of olfactory nerve ends. Perhaps I’ve learned to appreciate the lack of smell. Typical! The grass is always greener ... I’m unsure if I should be happy to go home at last. What will I do? I can’t read a book for more than five minutes before dropping off to sleep. I can’t indulge on food and drink because now the rancid butter smell puts me off. I can’t run because I feel tired and my head wobbles on a scrawny neck when I take off the brace. Where to next?

25 years later

I haven’t been a patient since and I have no desire to be a patient again. I’m happy I have been on the other side though. A month in hospital as a patient taught me more than six years at medical school and I’m very grateful for it. My brain has healed ... almost. I can still get tired easily and night shifts would not be a good idea. My sense of smell has improved, but never to the pre-head injury standard (which was pretty good). Still, there is the advantage of breathing easy when changing stinky nappies, mopping up vomit, or even working in microbiology when the anaerobic jar is opened. There is always a silver lining.

Poems

Nadia Ali

Angela Andrews

Jeff Brown

Glenn Colquhoun

Jessica Ford

Art Nahill

Nicola Pereira

Anja Werno

Nadia Ali

A Miscarriage on Mother's Day

By Nadia Ali -
August 10, 2016



This was written the morning after a particularly emotional night shift on my Obstetrics and Gynaecology rotation. Some patients stay with me longer than others, and I have thought often about the woman this was written about. Writing is one way I choose to process some of the tough everyday situations we face in medicine.

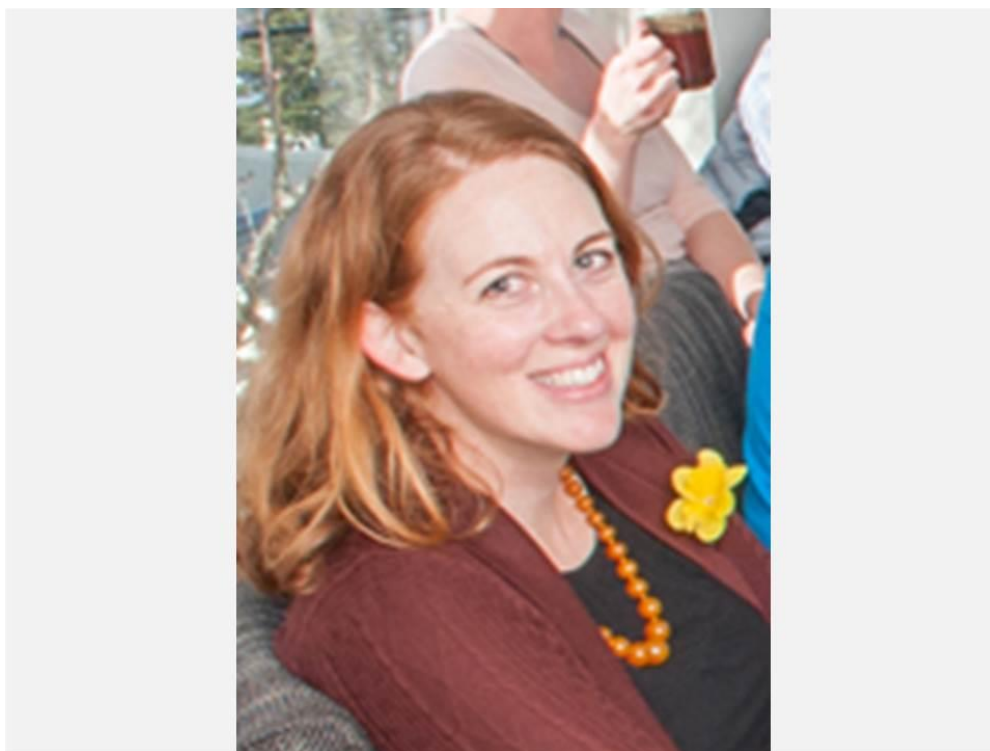
A Miscarriage on Mother's Day

Irony stalks down the corridor with her shoulders slumped,
 Dragging her trumpet along the linoleum;
 An ugly grimace shows her sharp teeth.
 Grief arrives in a rush, blowing the window open;
 It can often be gusty here.
 Motherhood comes to the door and asks after you,
 I tell her that visiting hours are over.
 Sentiment loiters in the waiting room
 then leaves, red-faced with shame.
 Hope makes a mad dash to the airport
 To catch you before you board the plane.

Angela Andrews

Mercy Clinic II

By Angela Andrews -
April 18, 2016



This is the second of two poems I wrote about being a patient at a breast clinic, which was an experience that threw all the routine questions, tests and conversations I'd been part of many times before – as a doctor – into a new light.

Mercy Clinic II

She releases you from the clamp
and guides you to the screen.
So quick you say and already?

There is your breast in black and white,
the mesh of fat and glands, ducts and vessels.

He comes up behind you and pauses.
These are your veins says the doctor,
this is your tissue, no calcifications
there. You nod in agreement, compliant, smiling as you wait
for him to say what he really means – no knives
and herbs, no breakfasts of berries, no faith,

no new lexicon or words for mortality and God and you realise
neither of you know what he means at all.

There are women who know, women who have been here
standing as you are, doctor and patient
in front of the lightbox, confronted
with something in the white tangle,
something caught on an inward breath.

In the photographic darkness he clears his throat.

He's going tell you the next step.

You stand in front of him without a bra.

Riddle

By Angela Andrews -
April 18, 2016



I was thinking about the symbols of medicine when I wrote this riddle. Although I don't particularly want to give the poem away before you read it, by the time I got to the end of writing it I was thinking as much about the persona of a doctor – what is required – as I was about the literal object.

Riddle

I've been to the big room.

I've picked you from all the others.

You're shapeless and you won't crease,

you can take hot water.

They can throw anything at you,

it will all wash out.

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The whiteness shows you are clean.

You are professionalism and hygiene.

You've been worn in and worn out.

On your lapel is a pin.

You don't breathe well

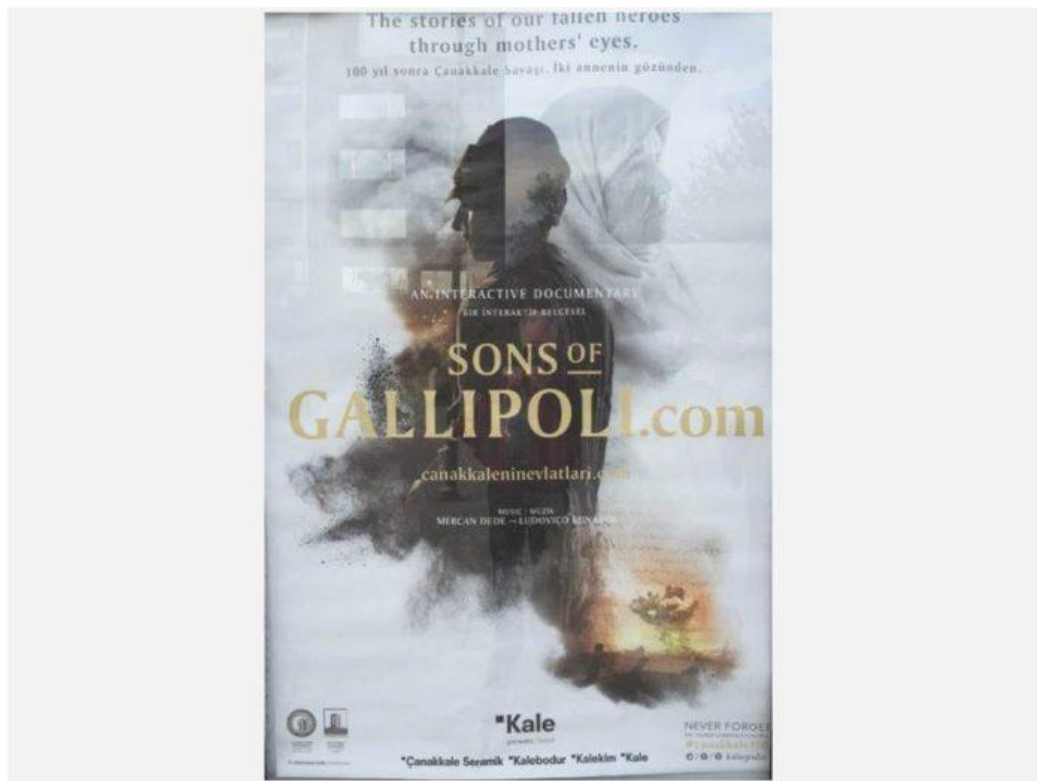
and they say you spread infection.

You scare children.

Jeff Brown

Tread Lightly For You Tread On My Bones

By Jeff Brown -
July 7, 2016



Three days on Gelibolu (Gallipoli) for the 100th anniversary of Anzac Day after call up at fortnight's notice in the ballot. Both my grandfathers were there, one for nine days, the other for the entire campaign. Guided by a local, Murat, I saw history through his eyes, shared tears more than once, and met his mentor Mustafa, before completing a kind of pilgrimage at the dawn service and memorials. I attempted to capture a few emotions amongst the myriad. Then struggled for a year until I landed on the single word at the end of the penultimate line.

Tread Lightly For You Tread On My Bones

Dad's dad went ashore

And Mum's dad too,

A narrow beach, of sorts,

Scrubby cliffs starkly in view.

100 year old trenches, snake and straight,
A few fresh poppies bloom,
Picked one to carry to Chunuk Bair,
On a pilgrimage of gravesites for the known few.

The rest lie entombed,
Beneath the soil we tread,
Reflecting and crying at the shame and the waste,
Of orders to charge, lives laid down for mates, not for generals.

Ataturk grew a nation from this,
Anzacs defined themselves too,
Many Brits, donkey tenders, medics, French, Irish, engineers, mostly Turks
Made up the half million wasted in 8 ½ months.

Do we despair or pay homage?
Is it for us, or for them?
A centennial of futility?
Or for glorious cause?

I weep with Murat,
Take the hand of Mustafa.
Two generations lost
On a peninsula of a generous host.

My heart now understands
What my head only felt,
That walking on bones carves
Wounds beyond help.

Solo Track

By Jeff Brown -
November 30, 2016



For many years my wife and I have enjoyed walking and jogging the Manawatu Gorge Track, often at the end of a working day. We talk and listen to birdsong mixing with our slightly out-of-breath exertions. People of all shapes, sizes and ages share the native bush-clad track. Among these were, quite often, a couple – of indeterminate years but obvious fitness – to whom we nodded acknowledgment but no more. Recently I twigged that ‘they’ were now just ‘him’. After a few solo passings I began to wonder whether she was not there because of accident, or infirmity, or dislike of the whole exercise. Or maybe she had left him, by design or permanently gone from this world. I wrote in the third person to try and see through his eyes, to crystallise how he might wander, trekking alone.

Solo Track

He can walk where

He wants to now,

No need to confer, defer

Arguing which path

Should extend them, without

Too much pain

Or ache the next day

When the bottle's empty.

He can run ahead now,

No need to wonder,

Should he be pushing

Her up the steep

Challenge in front of them,

Without shoving so

Much that they both

Slide away.

He can sit down

In silence now,

Screen and cross

Word off, no need

To trawl the net,

To trip over the

Reason, he has all

The time in the world.

Glenn Colquhoun

Doctor to Patient (on ornithology and the practice of medicine)

By Glenn Colquhoun -
October 30, 2015



I wrote this poem after contemplating almost 20 years working as a doctor. It occurred to me how often my head had been noisy during consultations over that time and how often I had been grumpy or tired or worried about what to do next – or perhaps had simply not liked the patient I was talking to – and how often this had affected my consultations. I was also struck but how often the challenging patient had taught me something and how the practice of poetry had taught me to find the amazing in the ordinary. The poem is about all of that I suppose. Poetry has shown me that every patient brings something remarkable and delicate to the consultation and that it is part of my joy, and a help to them, if I can simply be still enough to find that. In many ways I think of it as a love poem to patients. I could never have written it 20 years ago.

Doctor to Patient (on ornithology and the practice of medicine).

You have brought me a bird.

I have seen this before.

When you say,

‘I am sore,’

I see a bird.

When you say,

‘I cannot breathe,’

I see a bird.

When you say,

‘I lie awake,’

I see a bird.

You have brought me a bird.

There is a bird

in the room.

Should I stand on the table?

Should I stand on the chair?

It is singing.

Listen, it is singing.

It is there, in the corner of your eye.

It is there, on your shoulder.

Here, in the pit of your stomach.

Now, between your legs.

Inside your rattle-cage,

when I press

my ear to it,

I hear a bird.

Behind your knee,

in the creep-

dark shade,

hops a bird.

And in your sorrow-joy,

tip-winged and

unbearable,

hangs a bird.

Give me your hand.

Here, it is in your hand.

It is breathing.

Listen, it is breathing.

Should I dance?

I should dance my old man's dance.

You have brought me a bird.

How can this be?

You have brought me a bird.

– Glenn Colquhoun

Boy with a Runny Nose

By Glenn Colquhoun -
October 30, 2015



This is one of a sequence of poems I began to write a while ago to John Keats. He trained as a doctor and wrote a beautiful sequence of odes not long before his death. I have often read them and wondered what he would have seen in medicine if he had had the chance to practice. I decided to write some odes to him in response. The ode is an old and venerated form in poetry. It is usually written to a god and was originally sung so makes heavy use of the sound techniques of poetry. Odes have been redesigned over and over again by various poets throughout history and this is my take on the form. The topic was suggested by a 3 year old boy with a runny nose sitting on his mum's knee during a consultation. I was looking for a 'big' subject to begin my conversation with Keats but as usual it was the anti-heroic that caught my eye. God only knows when I'll finish the sequence though.

Boy with a Runny Nose.

Jesus would have looked like this
once, round-eyed, dog-tongued and panting,
drip, drip, drip, drip, sniffing,
before thoughts of kisses,
'is' ness, his father's business;
cheek to jowl, one tolling bell

of sweet, sad, sweet, sad song;
 our on and on, our right and wrong,
 our sing-a-long, our *Do-Ron-Ron*;

Mary, teary, tired and weary,
 the cross on which he hung.
 His cough: a knock on the innkeeper's door.
 His belly: five loaves and two fishes.
 His skin: the smell of frankincense and myrrh.
 His sneeze: the sneeze of life,
 some virus at host in a nose-blown
 bubble of holy snot like an
 insect in amber, poor little lamb.

But you truly are the Son of God,
 honey-muscled, grubby-chubby,
 arms and legs and chest and head
 gathering tentatively like
 wolves over a fresh carcass;
 swaddled in unconquered land,
 the ridge and drain of rib and brain;
 a pudge-fingered policeman
 checking every door at night.

In your eye the unmistakable fire
 smouldering, shouldering
 all our hiss and fizz and spark.
 Already old for time to shrink, make fool,
 though age itself the curl of smoke
 from ancient engines thundering past;
 pudding-round and squelching now:
 science, history, geography, art,
 napped on your mother's knee;

the breath of God perhaps, passed over
 and on, from Holy Land to hand and and;
 on camel back, the bloody hack;
 by sky, by sea, by Jesus wheeze,
 to port, to court, by horse of course;
 by biscuit, ticket, tide and rip,
 by ship, by crew, to you, to you;
 I am, I amber, God's meander, thick,
 slick, lip-licked, drip, drip, dripping.

– Glenn Colquhoun

Jessica Ford

Poems About Barry

By Jessica Ford -
March 11, 2018



Poems About Barry

Sadly, the following two poems are about the same person, the first patient I ever took a full history from – an elderly man who has influenced my life immensely. Although he had trouble with producing his words, right from the beginning of our conversation he had me in awe of his wonderfully positive outlook on life. Despite his diagnosis of metastatic lung cancer, he was in high spirits with a serenity about him. From the moment I met him, I knew that I wanted to put his speech into writing – and he was rather chuffed when I asked his permission to do so! He is someone that I will never forget.

Barry's Aphasia

"I have it and it stays

with me,

next minute it's gone.

It takes me back and

I'm happy."

So, you stay happy

by thinking back to memories?

"Exactly love,

exactly right.

I still don't worry."

This somewhat cryptic poem contains the words that Barry spoke to me while I was taking his history, with the words in italics indicating my response. I was in awe of his positive outlook on life, despite his inability to express himself (he had expressive and receptive aphasia due to a recent subacute stroke), and his diagnosis of metastatic lung cancer. His sense of inner meaning and happiness is one I will not forget.

Death

They say it's gone to

your bones,

persistent,

and stubborn.

I try to understand

your pain,

to search through

those smiling eyes,

and uncover

the truth that you

hide so well.

But I see no darkness.

I see no self- pity,

no misery

no anger,

no doubt.

No hint of pounding emotion

trying to escape from

within you,

a burning regret or

obligation.

I see a sparkle.

A fulfilment in you

that makes

you immortal.

Again, this poem reflects on Barry's positive outlook in life and the contentment of a life well-lived. He did not possess any sense of regret or fear, instead taking every day as it came and cherishing his time.

Art Nahill

Commitment

By Art Nahill -
November 17, 2015



Commitment

White hair
frames a face riddled
with effort.

The blue sea
of her hospital gown

spattered with egg

and oatmeal

archipelagos.

Her mind's a boat

listing badly.

It's 1964

(it's not).

I'm her husband

(I'm not)

come

to take her home again

(never again).

She's lived

in that house for more

than a lifetime, she says. Planted

all the roses.

I consign her

to the sea.

Doctor You'll Have to Take Me Word

By Art Nahill -
November 17, 2015



You'll Have to Take Me

Word For It Doctor

The Beatles played

me wedding.

They really did.

Before they were *The Beatles*

mind ya.

Just a pub band then.

Before Ringo

and all that druggy stuff.

Me husband couldn't stand

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the music.

They went on o' course

though we didn't.

If I'da known the future

I'da saved a picture.

Might be

worth something now.

Multitudes

By Art Nahill -
November 17, 2015



Multitudes

I carry many deaths

inside me though

not as a cat is said to

or a saint bristling

with arrows.

Not as an oak

in winter flies

its few brown flags

of surrender.

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Not the way the womb
sheds its lush red lining.
Not the way a virus storms

the cockpit of a cell
but the way a man
feeding pigeons in the park

watches as they wander
off when his pockets
are empty.

One Hundred and Two

By Art Nahill -
November 17, 2015



One Hundred and Two

The traffic's barely moving
on the main road out
of my heart.
That's how they explained it.
They said they could fix it
but I told them to save
their gadgets for someone
who could use them.

My memory's good
enough but I'm growing more regretful
every day.

Whoever said practice makes perfect
must have been a young man.

Sit here too long
and you can feel the world
shaking you
off its back like a wet dog.
They tell me I've got cataracts too.
That's why there are clouds
everywhere I look.

Nicola Pereira

You and I

By Nicola Pereira -
August 15, 2016



At seventeen, my friend suffered a traumatic brain injury in a car accident. The impact shattered our youthful sense of invulnerability and changed the trajectory of her life. For me, it was an early lesson in the uncompromising physics of head injury: the collision of innocence and painful experience, the evaporation of dreams and certainties, the gradual coalescence of a new identity in a changed reality.

You and I

Growing up, we were inseparable, you and I,

Twin stars in a firmament of our own design:

Castor and Pollux, partners in crime,

fish and chips, gin and tonic, fruit and wine.

Then you slipped out of our orbit

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and into your boyfriend's car.

You sped incandescent through the night,
a glowing comet with a tail of light,
until Gravity, the Prince of Entropy, cast his net,
sent you spinning head-long into a ditch.

They scooped you up and brought you in,
glassy-eyed and gasping on a gurney,
post-ictal, post awful, grazed and confused.
Post trauma predictions, guarded bad news.
The nurse stamped our passes to Life's waiting room.

I sat by your bed, day after day,
surveying the vacant strangeness of your lovely face.
I set lines for you every morning,
to draw you back from the deep unknowing.
Every night I manned the lighthouse of good hope,
to steer you clear from the rocks.
Every hour I willed you to build a raft and come flying home,
across the uncharted sea that lay between you and I.
At last, sunlight reached the obsidian depths
where you slept in still oblivion.
You rose through languid pools of grey-green light
as they carefully reeled you in.
They unhooked you and you wriggled free,

but you didn't remember me.

Your thoughts rolled back to you like fronds of kelp,
from the briny forests of your tangled mind,
you grasped at them with your shaking hand,
and lined them up on the beach,
to help you remember.

The doctors said that you were getting better.

But, cast adrift, I scanned the horizon
for the shimmering bits of you still missing:
the bits that shone like a freshly caught fish,
the flashing brilliance of a passing shoal,
the quick-silver subtleties of your soul.

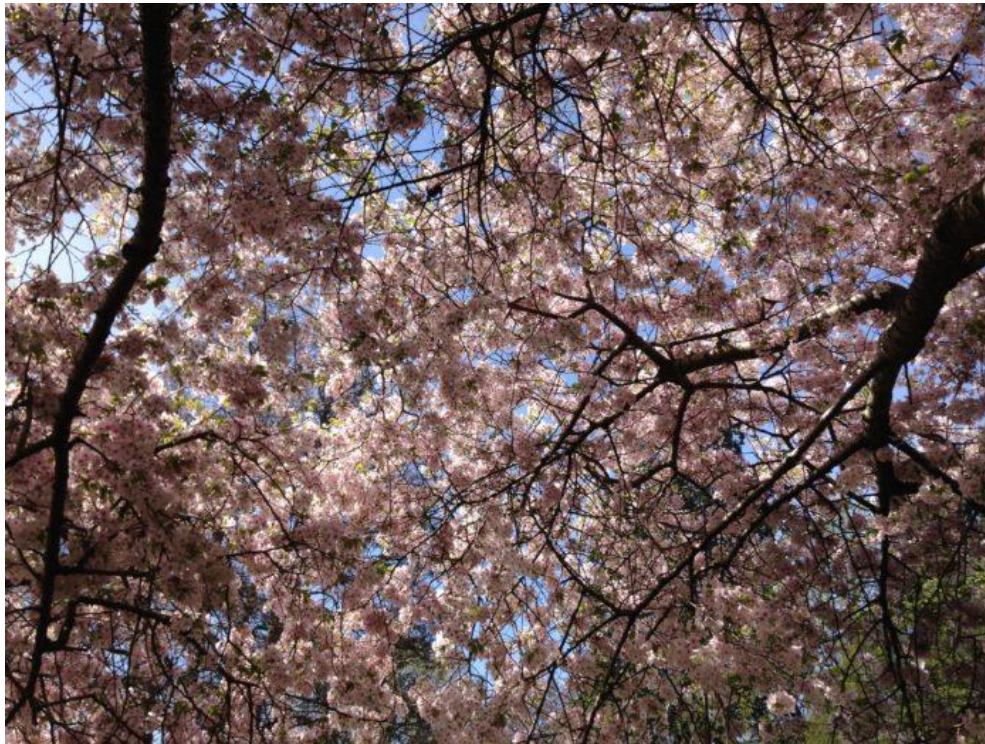
I matched my stride to your ataxic gait,
as we combed the beaches of your battered brain
for neural flotsam, from another time and space.

But the waste of it all flapped in my face,
like the sound of one hand clapping,
and slowly, with the water gently lapping,
we drifted apart, you and I.

Anja Werno

Crack and Burn

By Anja Werno -
February 28, 2018



Crack and Burn

Burn-out in medicine is common – as the recent ASMS survey has confirmed. The feeling that goes along with burnout has individual qualities, here is how it felt for me.

b

u

r

n

i

n

g

I
am
a flower
that does not open
with torn skin under my fingernails
from digging out a life, distracted and woeful,
my mind is confused, conscious but unaware,
my hand reaches out, my head hurting,
the ringing in my ears is no tinnitus,
the alarm bells of my soul,
here is a flower
unopened,
numb
am
I

Stories

[Greg Judkins](#)

[Lucy O'Hagan](#)

[Bridget Taumoepeau](#)

[Anja Werno](#)

[Jin Xu](#)

Greg Judkins

The Rose Garden

By Greg Judkins -
January 27, 2016



Robust banter and repartee arising from acid soil always catches my ear. This totally fictional story takes its roots from many interactions I have witnessed between couples, including patients and relatives. The ending wrote itself.

The Rose Garden

It was an exacting task, which fell due each year on the last weekend of July, and Francis Treecock always gained great satisfaction from pruning his magnificent rose garden. His secateurs were as sharp and tightly set as his mind, and he surveyed each specimen from several perspectives before decisively cutting back, as the best future prospects of each required. Of course he no longer needed to be constrained by the weekends, now that he was recently retired and had the full seven days at his command, but the last weekend of July had long been his landmark and had guided him well, and he would be unwise to deviate from it now.

As he worked his rose garden like a conductor nurturing the best from his orchestra, Francis reflected with contentment on his lot. With no mortgage remaining on the house and a suitably balanced portfolio of investments, he had been able to retire in reasonable comfort at the end of the week in which he turned sixty-five and became eligible for national superannuation. His rose garden was second to none in the suburb, with an admirable range of ornamentals, hybrids, standards and climbers, built up over the seventeen and a half years they had owned the property. His stamp collection had evolved from an eclectic range lacking specialisation, to become an outstanding and valuable archive of commemorative issues from throughout the Commonwealth. Francis was eagerly looking forward to having more time to devote to extending this collection, and hoped to be elected president of the Auckland Philatelic Society at the next AGM. As for his good health, he gave thanks to God for the head start provided by sound genes, and took a generous share of credit himself for his fastidious habits and self control. He had retained the slim build of his youth, although had never gained mastery over a lazy bowel, with its accompanying anal conditions, which had necessitated two very unpleasant surgical procedures.

And then there was Sheryl – sensible, practical and frugal Sheryl, a good cook of traditional fare both savoury and sweet, and endowed with a tongue both witty and astringent. For most of their married life she had sewn her own dresses, but she had tired of this in recent years as her interest in quilting had grown, and Francis was happy to indulge her by raising her clothing allowance to seven hundred dollars per annum. His dear wife could be relied on to deposit all relevant receipts in the appropriate file.

‘Francis Treecock! Your tea and crackers!’ The recently retired accountant winced slightly, but there was nothing new about Sheryl’s manner. Of course he would have preferred a wife to stroll out and take a polite if uninformed interest in his gardening efforts, and announce refreshments with a little more decorum than to yell at him through the dining room window, but it was only a minute past ten thirty, his habitual time for morning tea, and he accepted that he had much to be grateful for. He completed the pruning of the bush he had started on before turning to the stone path by the house.

‘If you don’t come now I’ll start adding salt to your tea cup.’ Words of encouragement met him half way. Sheryl had been a school teacher years ago, and retained a few skills in motivation for the tardy.

The wintry air outside was cutting, so they took their morning tea at the indoor table. Unlike his wife, Francis preferred savoury snacks between meals, and cast an approving eye over the small plate by his cup, containing two crackers each topped with thin slices of aged cheese and tomato, sprinkled with black pepper and decorated with a small tuft of parsley. ‘Ah, what would I do without you?’ he asked warmly.

‘Either starve yourself to death or bore yourself to death. It would be interesting to see which came first.’ Rhetorical questions have their dangers.

‘So, how does it feel to be sixty-five, my dear old husband?’ asked Sheryl as she buttered each half of her still warm banana bran muffin.

‘Much the same as it felt to be sixty-four,’ was the dry reply. ‘How does it feel to *look* sixty-five?’ The good wife quickly stuck out her tongue, three years younger than his.

Shortly, Francis sensed it was time to return to the incomplete and more predictable tasks of the garden, and rising, picked up his leather gloves and thanked her for the tea, and with his focus already out the door, lightly kissed the side of her head in passing.

‘You call that a kiss, Mr Treecock?’ Sheryl hammed up some indignation.

‘Well, it’ll have to pass for a kiss for the time being. That’s all one can muster under the circumstances.’

* * *

What freedom to go alone to the doctor! Francis usually liked to accompany her during her regular visits for renewal of her inhalers and antidepressant prescriptions, but he took little persuading that a routine cervical smear was not really a husband’s domain. As Sheryl sat alone in the waiting room, it felt as delicious as kicking off tight shoes at the end of the day. She selected a women’s magazine which Francis would scorn, and scanned an article on the wives and partners of famous sportsmen, an article not to her taste but seeming to suit the occasion.

On the examination plinth, her large pale body knickerless and sheeted, and with the curtain drawn around her, Sheryl was asked by Dr McAlpine, who was setting out her bits and pieces for the test on the small drawer unit by her feet, if she wanted swabs included with the smear.

‘What for? Just whatever you normally do, thanks.’

‘Well, if you have any discharge or other concerns in that area, we could do swabs for infection at the same time as taking the smear. It’s over to you, not essential.’

‘Infection, what sort of infection do you imagine I might have?’ returned the forthright patient under the sheet.

The doctor sought refuge in generalities, with only mild discomfort. ‘I don’t expect you to have any, but sometimes we come across all sorts of genital infections. Anything from harmless annoying conditions to sexually transmitted infections, whether suspected or not.’

‘Mr Treecock is far too busy making love to his roses and stamps to be bothered with that sort of frivolity,’ returned Sheryl, effectively sealing off conversation for the remainder of the procedure.

Back at her desk, as she entered some brief details on the computer, Dr McAlpine noted something that led her to ask, ‘Would you be happy to have another blood test soon, Sheryl?’ and went on to explain that last year she had been found to be pre-diabetic and that this should be kept an eye on, in case it was progressing to full diabetes. ‘Did the practice nurse talk to you about this? About reducing the risk of becoming diabetic by changes to your eating and getting more exercise?’

‘Did she ever, and Mr Treecock has been reminding me of the details at every opportunity since!’

* * *

Several days later, Sheryl received a phone call from Nurse Maya, advising that the blood sugar test was worse than last time and inviting her back for a review of her diet and weight.

'I hope I haven't become diabetic? The Gestapo would micro manage me to death!'

'Nearly, Sheryl. You're on the edge of diabetes. We'll have to make some changes I'm afraid, but let's talk more about that when you come in.'

'What about the cervical smear, Maya? Is that back yet?'

'Just a moment while I check for you ... yes, normal. When would you like to pop in again about your sugar levels?'

After agreeing on a day and time, Sheryl was ending the call when Francis came into the room. 'An interesting conversation, my dear?' he droned like a wasp against a window.

Why does he always dress his nosiness up as polite curiosity? 'Just a call from a health professional regarding my personal wellbeing. Of little interest to others.' She turned toward the lounge, but knew there was no escaping.

'Everything in order, I trust? Health is an investment for the future, and one must take good care of one's investments.'

Rah rah blah blah, one must this, one must that. 'If you must know, my attentive husband, the nurse wants to see me to discuss the results of a blood test I had. Nothing too fatal, you'll be pleased to hear.'

'Ah, that will be a follow up on your pre-diabetes, no doubt. If you ask my opinion, I'm sorry to say it is likely to be worse than last time, judging by what I've observed.'

'Oh dear, I must have asked without realising what I was doing. That's what happens when you've been married as long as we have.'

Francis had followed her into the lounge and now picked up the newspaper and lowered his long stooped frame into his recliner. But he had no intention of reading it just yet. 'When does the doctor need to see you again?'

'She doesn't.'

'I thought you said she wanted to discuss your test results.'

'That was Maya, the nurse.'

'Don't waste time seeing the nurse, you should see the doctor.'

'Well, I've made an appointment to see the nurse, as she requested, and I'm happy to stick with that plan, thank you very much.'

'I'll come with you, of course. When is the appointment? I've done a spot of reading about pre-diabetes, and owe it to myself to be there to keep you both honest.'

Sheryl Treecock's round face suddenly reddened, and she turned away from him toward the window, and was silent for a while, before responding with, 'You can come if you insist, but you might find there's also an embarrassing matter the nurse wants to see me about. When I had my smear the doctor took swabs for infection, and I've caught something. I don't know who or where it came from, but it seems that I caught it somehow.'

Francis held his breath. Retirement was meant to be a time of ease. Experience had taught him that under such circumstances it was helpful to undertake a simple mental discipline, while formulating a careful response. Slowly he commenced counting backwards from ten, but couldn't maintain concentration.

His wife kept her face to the window to avoid his scrutiny catching her slight smile, and she gazed out at the rose garden with a new appreciation of its thorny branches.

Makalofi

By Greg Judkins -
January 27, 2016



OLYMPUS DIGITAL CAMERA

This story is a tribute to the many older Pasifika women who I find warm and charming, but for each of whom I realise there is a back story which I know next to nothing of. I have tried here to explore how compassion can be stymied by barriers to communication.

Makalofi

My name Makalofi, I seventy two, I stay with son family after Matiu passed ... sorry for story no good, not talk to recorder ... recorder on? ... OK, go? ... my name Makalofi, Akanesi take me to doctor, Akanesi marry our son, take me to doctor, doctor smile, ask if OK, I say yes doctor thank you, ask something to Akanesi, drink my pills? Always! My pills beautiful for me, not have heart attack, not stroke ... he hold my hand, look hard at watch ... do pressure in my arm ... I stand on his scale, doctor shake head go up he say ... doctor do on his computer, give paper to Akanesi, say things to Akanesi, say too fast, smile at me, I say what? Akanesi say tell later ... at home Akanesi say doctor say I fat and lazy, not eat taro, do more work he say ... I try, sorry.

Makalofi is a delightful seventy two year old Tongan woman who joined our practice last year after her husband died, and she came to live with her son and his family, who are patients of ours. Like many Pasifika folk her age, she never learned to drive, and her husband would probably have prohibited her from doing so even if she had wanted to, so her daughter-in-law, Akanesi, brings her to see me for regular review of her diabetes and

hypertension. Akanesi also assists with interpretation and conveying explanations and advice to Makalofi in Tongan, but I really ought to look into getting a professional interpreter involved, as I feel uneasy about how well Akanesi relays the sense of what I want to say. She often speaks in an abrupt, almost military manner to her mother-in-law, and my statements of two or three sentences seem to be passed on as a compact missile. To be honest, I'm not sure how much Makalofi does understand, or hear clearly, and I often find myself talking to Akanesi instead because it seems more time efficient to do so. Makalofi is at high risk of having a cardiovascular event such as a stroke or myocardial infarct, but at least she seems to be taking her medications reliably. I'm afraid her weight is climbing steadily in spite of my best efforts to get her to comply with dietary measures and getting more exercise.

Akanesi good cook for me, corn beef and taro and cabbage and carrot last night, I cut up carrot for her ... Tevita give me taro, Tevita good son, too busy man Tevita, work hard make concrete pipe, Tevita put taro on my plate, Akanesi take off plate, Tevita get angry, shout things ... I go my room, baby asleep in room, baby Langi beautiful, look at her, touch hair, make feel happy inside, lie on my bed, shut eyes lie quiet on bed ... I feel all my tooth with tongue, six tooth left, *lo* only six now, feel with finger, this long one move, hurt, I eat other side ... in morning I say Tevita I loose tooth, hurt, he look say get all out, get plastic tooth ... Akanesi she say no, too much money ... OK I say, sorry, it OK, it OK.

We just shouldn't be seeing so many neglected dental abscesses like this. They must be very painful and are totally preventable. Oral health care in this country is rather scandalous, with more marked disparities across the socioeconomic spread than for any other aspect of health I can think of. If Makalofi had an abscess on her leg she would have it treated immediately, without any cost to her, in our public hospitals. Provided of course she could demonstrate that she had New Zealand residency. Same story with an abscess in the breast or on the perineum or in the ear – prompt, free treatment – but for dental abscesses, different rules apply. Makalofi will only get assistance from the dental service at the hospital if she turns up by 6am with forty dollars to pay up front, and then wait in a long queue, hoping to be seen that day. Those antibiotics will help a little, but the pus won't be able to drain until that tooth is removed. Poor lady, she must be pretty stoical.

Akanesi try hard, try her best ... hold chin one hand, hold tooth with hanky, pull hard, say shit! then try again ... excuse me say that word, that what she say, sorry ... oooh, hurt too much! ... even four Panadol no good, make me drink four first, but no good, spit some blood but tooth stay ... Akanesi get Tevita tool thing, tool from garage ... I shake head, hold face, mouth keep shut, Akanesi try make open mouth, I shake head, Akanesi say very bad word, hit me with Tevita tool ... sorry I say that, but Akanesi do that thing ... I go my room, lie on bed, cry ... she try help but no good, no good for me.

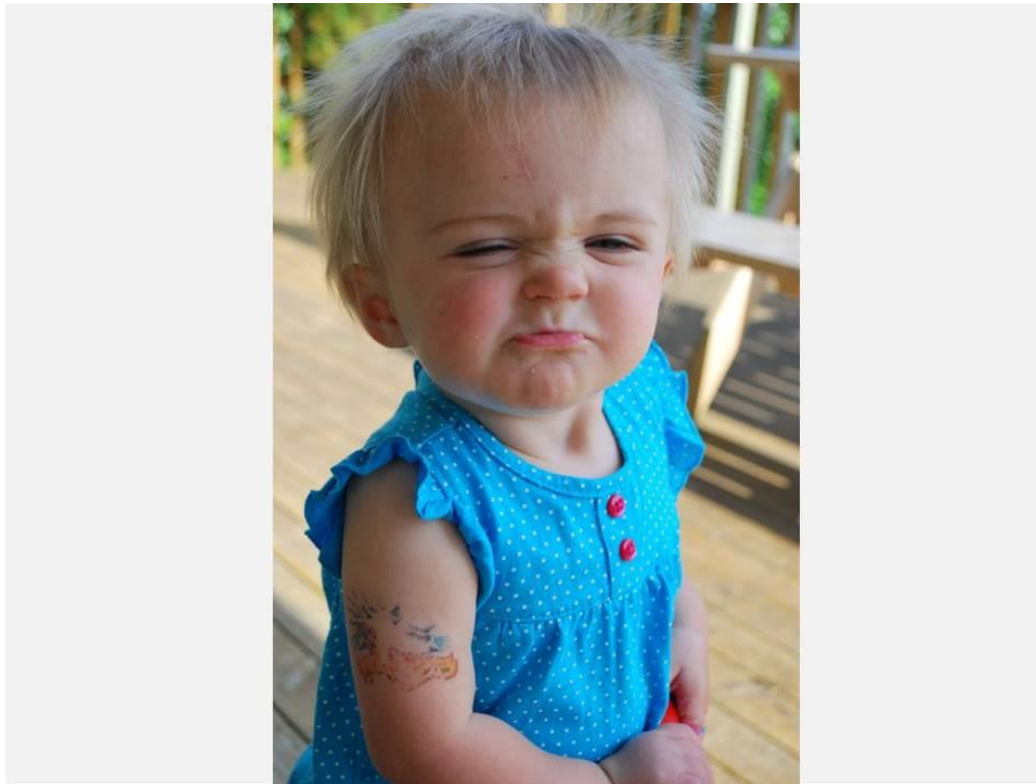
This is the first time I have seen Tevita with his mother. I notice he has a lovely touch with her, supporting her on his arm as she walks unevenly in. The poor fellow has been made redundant and seems a bit down in his spirits, and really has no idea what is going on with Makalofi's usual medication. They have come today because of increasing pain in her left hip, which is likely to be osteoarthritic, but when I mention that it is almost five months since I last saw her and that she must be well out of pills, he is surprised and puzzled. He asks Makalofi something and she apparently replies that Akanesi had told her she doesn't need them anymore, but she will be OK as long as she doesn't eat any taro or biscuits. It is, however, gratifying to find that her weight has come down 8kg since the last visit, but her blood pressure is high today and I emphasise to them both the importance of her remaining on regular medications. Tevita readily agrees that if he is still out of work he will bring his

mother back for another blood pressure check in a month's time, otherwise it will have to be Akanesi.

I dream place feel warm, lovely ... warm, no pain in leg, no pain in tooth, walk good like young ... I see Matiu, Matiu strong for me, make safe ... I smell market, ripe banana, fish, coconut ... beautiful, the fly they no matter ... very warm place, make sleepy ... no Matiu now, now see Pae, Pae little sister, Pae smile for me ... Pae no come New Zealand, Pae stay Nuku'alofa ... I wish stay Pae house, Tevita maybe send money, good son for me, stay with Pae, good sister, be warm, be happy.

Family Outing

By Greg Judkins -
January 27, 2016



Sometimes we go into a consultation with great principles and plans, but the devil of real life pulls a thread, rigs a trap for us, and it all slowly unravels beyond any hope of salvation. This story is a collage of numerous such consultations that I wish I had been able to record, to laugh and cry over with colleagues.

Family Outing

Who's next? Storm Wepiha and Rainbow Wepiha-Wilson. New patients. *That's good*, thought Dr Fiona McAlpine. *Still building up my side of the practice, and I like mums and kids.* She said hi to them as they walked down the corridor to her room, but Rainbow just stared back, holding her mother's hand, and her bigger brother lagged behind and was reluctant to come. Once Storm saw the old keyboard and phone on the little table, however, he rushed to them, shoving Rainbow away when she followed his interest. She cried a routine protest, and turned to her mother, already seated, who automatically produced a lollipop from her handbag. Soon a sticky sucking mouth, a neglected running nose and wary eyes were turned towards the unfamiliar doctor.

Fiona introduced herself to the mother, who said, "Pleased to meet you. I'm Diane," and put her opened Coke can on Fiona's desk next to the blood pressure machine. The door opened again and in walked a barefoot teenager in a yellow singlet and tan cargo shorts, lugging a

baby in a car pod. She avoided eye contact and headed for the spare chair. “My kid sister,” explained Diane, noting Fiona’s surprised look.

“Where would you like us to start?” Fiona seemed to address the room, looking around as she spoke. Storm had already tired of the old gadgets in the toy corner, and was trying to climb onto the examination couch. “Let’s start with you, buddy, do you know what you’ve come to see me about?”

“There’s really nothing wrong with him, just need to get another referral to the Orthopaedic Clinic. Rainbow’s the sick one. Coughing all last night and ...”

“No, I don’t want you climbing up there thanks,” said the doctor, turning her swivel chair. That’s a boy, there are more toys and books in that red box over there.”

“Yeah, and last night she was hot as. Kept us all awake.”

Storm then discovered the taps over the hand basin. Fiona tried to ignore him and concentrate on Rainbow’s story, but very soon found herself turning again and asking him to find a toy to play with. She got up to turn off the tap and help Storm choose one.

Then back to Rainbow, progressing as far as getting her up onto Diane’s lap to be examined, although she had to compete for lap space with Diane’s abdominal apron. Rainbow sneezed, sending twin mucous candles down over her lips. Fiona reached for her tissue box and Diane pulled out half a dozen leaves, enjoying the luxury of tissues she didn’t have to pay for.

The young doctor had a nice approach to examining apprehensive children, letting them hold the stethoscope first, placing the diaphragm end on their forearm before sliding it gently up to the chest as it warmed, but she was interrupted by –

“How do you turn this on?” Kid sister was trying to weigh herself on the electronic scales behind her.

“I’ll show you when I’ve finished examining Rainbow.” A touch of irritation. Fiona had half turned to speak and saw that Storm had opened one of the drawers under the examination couch, and was playing with the demonstration inhalers and spacers kept there. “No, shut that please Storm.” She briefly waited for a response from either the boy or his mother, then got up and carefully closed the drawer and directed Storm back to the designated playthings.

“I’ll tell your father if you’re a naughty boy,” from the otherwise inert Diane.

Fiona resumed examining Rainbow, checking her temperature and then looking for rabbits in the burrows of her ears. Rainbow was being a cooperative girl, and placed a sticky hand on Fiona’s knee in a gesture of acceptance. Diane had a sip of her Coke. Kid sister’s baby had woken and was being rocked in her car seat, and talked to.

The phone rang, Vanessa on reception saying that the father was asking to join them.

“No, I think we have enough people in the room already,” said Fiona, adding hopefully, “And they’ll be out soon.”

"Is that Philip?" asked Diane. "He's meant to be looking after S.F. I can hear her crying. Yeah, he can come in."

Every consumer has the right to have one or more support persons of his or her choice present, recited Fiona silently and resentfully to herself.

"This is Philip," introduced Diane as he flustered in. Philip gave Fiona a short nod, but was focussed on handing the distressed toddler to her mother. Her bottle was empty, apart from a residual smear of milk. Diane unscrewed the top, poured in a little of her Coke, replaced the teat, and calm was restored, for the moment.

"I didn't catch the little one's name." Fiona's curiosity was rising above the unfinished tasks in the consultation, and her urge to comment on suitable drinks for children.

"We call her S.F. Short for San Francisco."

But Storm now had both taps on, and as Fiona turned to the sound, Philip barked, "Stop that son! Turn them off, now!"

A narrow opportunity opened, giving the doctor a moment to explain about Rainbow's viral infection, what to do and what to look out for. Then S.F. was off again. Diane put her on the floor and gave her her opened handbag containing sunglasses, keys, cards, cash, lollipops and lipstick, buying an extension to the time of peace, while the toddler pulled each item in turn out onto the carpet. She told how Storm was born with a club foot, not too bad, and had only needed one operation when he was tiny, but he had missed several Orthopaedic appointments over the past two years. Diane simply wanted Fiona to write to the Super Clinic with their new address and her mobile number, so they could get him looked at again.

The sudden sound of running water behind her caused Fiona to turn sharply.

"If you don't turn that tap off right now the doctor'll give you a needle," warned Philip.

Instinctively defensive, Fiona retorted, "We doctors don't give needles; only the nurses do," followed by an immediate sense of dismay at having not been supportive of her colleagues. The water stopped and Storm started climbing onto a plastic chair to reach for the paper towels.

Rainbow had extended an arm and pressed a few keys before somehow exiting the computer programme while they were talking, her lollipop finished and the stick discarded on the floor.

Kid sister had worked out how to turn on the electronic scales, and announced that she'd lost a kilo.

Fiona asked if she could have a look at Storm's foot.

"Don't you believe me? Take your boots off, son." Diane's words, like some of the sower's seed, fell on stony ground. Storm turned his attention to what was in the other drawers under the couch. S.F. had completed her exorcism of the bag contents and was trying to pull herself to her feet by tugging on her mother's long purple dress. Diane turned to her partner

who had been preoccupied with texting. "Can you take her out again? Drive her round the block or something. She's due for a sleep."

And a nappy change, thought Fiona.

As the door closed behind the father, with a toddler arching her back under one arm and an empty bottle in his hand, Diane confided, "Actually I didn't want him to hear me say the reason we're changing doctors. I wanted a lady doctor. The bastard we were going to was real creepy. Justine's sure he wasn't wearing any gloves when he examined her down there."

Her baby was crying, but kid sister's head was bowed, and dead still. Fiona's interest suddenly intensified but her batteries were almost flat.

"If Philip heard, he'd go wild," added Diane.

Rainbow had found the old keyboard unattended on the play table, and had just started happily patting the keys with all her fingers when her brother decided that was what he now wanted to play with. Screams accompanied the struggle for possession.

"Give it to her!" Ignored once again, Diane hauled herself to her feet, took a couple of quick strides across the room and whacked the boy across the side of his head with her open hand.

"Oh no, Diane, I'm sure you're feeling stressed out, but we're not allowed to hit our kids like that." An incredulous stare came back at her. "He's quite a handful, isn't he?" Fiona added, trying to sound sympathetic.

"What's your problem?"

"Diane, have you heard of the Positive Parenting Programme? There are free classes in parenting skills, especially for families where the kids are hard to manage. Would you be interested?"

"No, why should I? We're OK."

Lucy O'Hagan

Silverbeet

By Lucy O'Hagan -
November 3, 2016



Silverbeet

I once knew a man of means, who lost it. It wasn't sudden. I witnessed him diminish over many years.

I ran behind, so he always got to spend at least 20 minutes with my receptionists chatting. You know, the weather, rising petrol prices and the like. He liked women. He felt better by the time he got to my consulting room. Which was a relief. Even then I had to work to keep my heart un-sunk, so to speak.

He sort of slouched, a great mass of humanity. It felt bad but I had little to offer.

It wasn't so much him, as the relentlessness of his losses. He lost his business, his family, his home, and finally his mind. In the end, after many years of takeaways he was left with only his car. So he slept in it.

At that point, I did wonder about who was out there to help. It was a fleeting thought. After all, I wasn't inviting him to stay on my floor; I wasn't taking the shirt off my back. Of course, I was somewhat protected, being a doctor and all. My only obligation was during the appointments, which were frequent and onerous. Outside of that I was free to go about my business, and if he was sleeping in his car ... well, whose business was that? Not mine. Some social service, I suppose.

Well soon he parked his car outside the medical centre and slept there. He started planting silverbeet along the edges of our sandpit. And he struck up a friendship with our elderly neighbour, who lent him garden tools. It was a mutually satisfactory arrangement as she was in need of friendship, but not a gardener. She didn't go so far as to invite him in. So he stayed where he was, in our parking lot.

(Many years later my receptionist confessed she had once given him \$10 for a cup of tea.)

Still, it was disconcerting. Him being there and all. Especially after hours.

Mind you, he was clean, taking advantage of the garden sprinklers on timer, and friendly. We were in a nice part of town. The other patients responded to his greetings, but seemed unsure what to make of him. He was at a disadvantage because at that time silverbeet was a somewhat unfashionable vegetable. Still, beggars can't be choosers. And we could hardly ask him to leave, park elsewhere. So we let him in to use the loo at his convenience.

Despite the conveniences he still slouched miserably and I was getting somewhat low on energy myself.

So I told him I was sorry.

Sorry about his mother, who had died when he was born. Sorry about his father, who had lived on, drunk. Sorry about the violations and the voices.

Sorry about the pain of his gout. Sorry there was nothing I could give him for it due to his allergies and dyspepsia.

And sorry about the bill. He was, after all, no longer a man of means. He said he was happy to pay. Things were looking up.

I had come across him, leaving, at the end of a long day. He was bent over a small patch of dirt between the 'doctor only' car park and the fence that hid the crushed cartons, medicinal waste and empty oxygen cylinders. He was planting a row of brussel sprouts. A great autumn crop, he said, catching my eye.

He sent me home with a bundle of silverbeet. Actually, it was rather good.

Bridget Taumoepeau

Te Taha Wairua – a neglected concept

By Bridget Taumoepeau -
April 21, 2017



Te Taha Wairua – a neglected concept

In the 1980s, Professor Sir Mason Durie introduced us to the health model of Te Whare Tapa Wha, in the context of providing relevant assessment in mental health services for Māori.[1] This model has been widely accepted and used in many settings. I note, for example, that a study of smoking cessation in Māori also used Te Whare Tapa Wha.[2]

While this model was developed for Māori mental health services, it is also applicable to non-Māori services and to anyone interested in a holistic approach to health and wellbeing. I know, for example, of Pākehā who use it as a measure of the health of their community and environment.[3] In writing this, I am considering a wide range of settings that require assessment for the purpose of promoting health and healing.

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For those unfamiliar with the model – in brief, it describes the principle that for a person (the house or whare) to be healthy, the four walls must be strong. These ‘walls’ or corner stones are physical health (te taha tinana); mental health (te taha hinegaro); family (te taha whanau) and spiritual health (te taha wairua).

The government organisation ‘Careers New Zealand’ has published a description of Te Whare Tapa Wha, describing the four aspects of health.[4] Te Taha Wairua is outlined as follows: “This refers to spiritual awareness. It is recognised as the essential requirement for health and wellbeing. It is believed that without spiritual awareness an individual can be lacking in wellbeing and therefore more prone to ill health. Wairua explores relationships with the environment, people and heritage. Spiritual awareness is key to making effective career decisions.”[5] There could hardly be a stronger statement as to the importance of spiritual health.

As with understanding any model of health, we should reflect on how this applies to us as practitioners. How would we ourselves measure up in terms of the four cornerstones of our own health? Do we, in our everyday lives, consider the importance of these four aspects of our lives to our own wellbeing? How often, when we have become unwell, have we been told that we are not attending to our physical health, or to our mental health, or giving enough time to our families – a source of strength and support as well as sometimes an anxiety or responsibility? How often, however, would we consider our spiritual health in making such a self-assessment? Not often, I would suggest. If we are unfamiliar with this aspect of our own wellbeing, how can we incorporate this into our assessment and understanding of others?

First of all, we have to know what spirituality means. What is the spiritual aspect to our lives? This may vary markedly from person to person, but could be considered to include the idea of our world view; the beliefs or practices that sustain us; an awareness of a life force greater than or outside of ourselves; ways that we make sense of life; what gives meaning and purpose to our lives; spiritual or religious communities that we belong to; how do we feel connected, and so on. Such spirituality may or may not include a traditional religious belief system.

Aside from a possible lack of knowledge about spirituality, we seem to have a reluctance, a shyness, a lack of confidence about asking about this part of people’s lives. With an increasing secularisation of society, an ability to have a relaxed talk of God, a Higher Being or our world view seems to have sunk without trace. And yet we hear of people who have taken up meditation, attend Buddhist retreats, follow a guru who inspires them, have developed rituals within their families for special occasions, such as the naming of a child, attaining adulthood, death, etc. One problem may be that we often conflate spirituality with organised religion. Those who do not practise the latter may not recognise that they do have a spiritual aspect to their lives, whereas those who do practise may be reluctant to talk about this, as society in general and, perhaps, psychiatry in particular have been dismissive of these beliefs and practices. In addition, saying that one meditates every morning is considered admirable, whereas talking about one’s prayer life and personal relationship with God may be looked upon askance.

As with all aspects of medicine, one’s own experiences may affect the way we practise our skill. Putting this in context, those of us with physical problems may be very sympathetic to a fellow sufferer, be knowledgeable about available services and form a good rapport with the patient. On the other hand, if their difficulty is minor in contrast to one’s own, it is easy to

belittle their distress. Similarly, if we have experienced any aspect of mental illness (and, after all, we are not exempt from the statistics of one in four or one in five being likely to have at least an episode of mental distress in our lifetime), this may make us better able to empathise with the person in front of us. But what of spirituality?

If Te Taha Wairua is considered 'an essential requirement for health and wellbeing', then we are being negligent if we ignore this aspect of people's lives. Encouraging such a conversation may be an opportunity for people to realise the importance of spirituality; to recognise the spiritual side of their lives; to strengthen the way that they develop their beliefs which anchor them in life and link them to others. New Zealand would be one of the most secular societies, yet people are searching for meaning in their lives. Sometimes they don't know where to look or what to say, yet may already have the answers within themselves, waiting for someone to help them discover this aspect of their lives.

Each doctor, health professional, counsellor, therapist develops their own style of engaging a patient and learning about their concerns and also their strengths. Such inquiry needs to include getting in touch with the spirituality of the person in front of them.

And so to the practical ways to achieve this – making an inquiry into how much of this is taught in training programmes and what, if anything, needs to be improved; developing ways to ask about this subject, with which we may be unfamiliar – ways that do not upset or alienate people; learning from other professionals who may be more familiar with this area of assessment; committing ourselves to addressing this issue; modelling to younger practitioners that this is part of holistic care; seeking support within our professions from like-minded colleagues – in other words, developing this skill as we would any other practical skill in order to treat and heal the best we can.

[1] Durie, Mason. 'Indigenizing mental health services: New Zealand experience'. *Transcultural Psychiatry* 48(1-2) 24-36.

[2] Glover, Marewa. 'Analysing Smoking using Te Whare Tapa Wha', *New Zealand Journal of Psychology* Vol 34, No.1, March 2005.

[3] Fr. Phil Cody SM, personal communication.

[4] www.careers.govt.nz/practioners/career-practice/career-theory-models/te-whare-tapa-wha

[5] Ibid.

Anja Werno

Behind The Door

By Anja Werno -
February 14, 2016



My father died on the 8th of December of 2005 in Germany. He died of primary hepatocellular carcinoma. I managed to get back to Germany just in time to see him alive and say good bye. I have always been fascinated by the emotions that death evokes in people and felt the best way to recall my own experience with my father was to take a step back and create a fictional piece.

Behind The Door

A long narrow corridor stretches in front of me. Occasionally, when a door opens, gleams of sunlight play on the dark walls.

I feel my throat close. It is a hospice. The smells of disinfectant and disease are faint. The smell of Christmas herbs lingers. I can discern baking and coffee and suddenly feel hungry. That is not what I should feel. I know.

The architraves are decorated with pine branches and holly, Christmas stars and silver bells. At the end of the corridor looms a tree, hung heavily with lights and shining ornaments. I find it hard to tear my gaze away. I miss Christmas and hate it at the same time.

I walk towards Room 11 and open the door.

The bed sits like a throne; at the centre of the stage where the play will unfold. The blankets wrap themselves around a form, a form that once belonged to a healthy man.

A head shines yellow against the starched white linen. Its eyes are shut. I can't find the person I know so well. He is hidden somewhere.

I look to the window, where a candle glows, filling the room with the scent of pine. The room is sparse: a bed with a body, a table with tissues, a seat for the relative who watches, a place for the voyeur.

The face intrigues me. The skin is folded like terraced fields, paper thin and parched. A pool of liquid has collected in each canthus. Tears?

Dried mucus covers the mouth. With every breath the mucus blows bubbles. Small ones, larger ones. All of them burst.

He looks calm in his sleep, full of good-will, carefree somehow.

Again I try and find the familiar and fail. Tentatively, my hand works its way onto his forehead. A tender touch. The head balances lightly on the pillow, it seems to have no weight. My dry hand strokes warm, moist skin.

Without warning the eyes fly open. My hand withdraws and I feel caught. The dry mouth shapes into a smile. There is warmth in the old and haggard face. I can feel it running through me even though I shudder.

His bony hand looks for mine.

"Are you tired?" I ask.

"No, I'm not. I don't want to sleep," he says. "I'm just resting."

The pressure around my hand increases.

"I'm afraid," he says quietly.

I fight the impulse to pull my hand away, to pull myself away as if I would hold up the inevitable by leaving.

"I'll stay," I say.

"Thank you." He closes his eyes again, resting.

I sit in the chair next to the bed and listen to the regular breathing of the old man. The rhythm makes me feel sleepy and I begin to drift off.

Suddenly, a change. He is coughing, rasping.

“What can I do?” I ask him. My hands feel sweaty and there is a tremor in my voice.

“Nothing. Just be here. Stay with me.” His voice is weak now.

I fold my arms around the fragile body and feel a monumental tiredness descend on me. When the coughing has stopped and the regular flow of breath resumes we both rest.

My head lies next to his on the pillow, so I can follow every raspy breath with mine. The face has a different colour now. Greyer, I think, carved. The rasping changes its melody. It is sporadic; sometimes deep and harsh like falling water, sometimes delicate like the crackle of silken paper.

At 10.32pm the rattling noise stops. The eyes will not open again. It is all silence, a silence that trumps all other noise.

The Christmas candle still flickers. The tears flow freely now. My father is gone.

Jin Xu

Monday Morning

By Jin Xu -
April 18, 2016



I wrote this piece during my GP rotation as a fifth year medical student. The GP and I had been visiting an elderly gentleman who was at the terminal stages of heart failure. He passed away during my time there. The inspiration, interestingly, came to me when I was swimming one weekend, and my own shortness of breath underwater reminded me of the very scenes of our home visits.

Monday Morning

Monday morning, my GP tells me that Mr. S. passed away over the weekend.

On Saturday, I went swimming.

I met Mr. S. as a medical student. Through all the home-visits, handshakes and awkward eye-contact there was one observation not even a medical student could miss: breathlessness.

I have never been a good swimmer.

Mr. S. was always breathless. He was breathless when he moved and he was breathless when he was still. He was breathless when he talked and he was breathless when he was silent. He was breathless sometimes, and other times, he was even more breathless.

Soon enough my strokes slip out of sync. Fatigue creeps like a snake through my vessels, stabbing its lactic acid deep into every muscle.

I recalled the only conversation I had ever had with Mr. S. alone. We talked about his house; the one that he lived in now by himself. He had built it some thirty years ago and he wished to die in it. He became fatigued after only a few exchanges and politely excused himself from our conversation to stare up at the ceiling. Feeling helpless, I let my eyes rest on the view of the sea through the sliding doors of his bedroom. To my surprise, Mr. S. mumbled, 'You can keep talking.' I wondered how it might have felt to pass time here, alone, with only the sound of one's own breathlessness for company.

As oxygen changes from being a commodity to a luxury I bite into the air, like a boy longing for cake. I ask myself how much longer I can stand being underwater. My chest, my mind, every inch of my body protests.

Mr. S. passes away.

I stop swimming and rise to the surface.

Suddenly, neither of us are breathless any longer.

Project Team Blogs

“Medicine is my lawful, wedded wife, and literature is my mistress” – Anton Chekhov

By David Galler -
October 30, 2015



An introduction to The Medicine Stories Project, by David Galler.

I have just finished a book by Abraham Verghese called *The Tennis Partner*. The author is an Infectious Diseases Professor at Stanford; the story, a semi autobiographical one, is set around his relationship with a drug addicted medical student during the 1980s, at a time when Verghese’s family had moved to El Paso and his marriage was disintegrating. The relationship between the wiser physician and the younger student is the major thread of this story and defined through the metaphor of tennis. Verghese himself is a very good player and was well coached as a boy in India; David the medical student had been on the professional circuit and now struggling in his recovery from a devastating addiction to cocaine.

The book is beautifully written and for anyone with a love of medicine and people, and tennis, it is a must. Verghese’s patients have AIDS, in an era of fear when effective treatments did not exist and the diagnosis was a sentence of death (in 1983, I remember the

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cashier at the staff café at the London Hospital in Whitechapel not accepting £1 notes for fear of catching the yet unnamed virus).

His descriptions and stories of those patients, their presenting signs and symptoms, are very human and resonated beautifully with the physician in me.

So too was the way he recounted some of the great tennis players from the bygone era of my childhood. Stories about the legendary Australian tennis coach Harry Hopman and his training routines – the endless practice of the one, two, three traded ground strokes followed by a cross court backhand or down the line forehand; Ken Rosewall sliding on the grass into his trademark sliced backhand; Rod the rocket Laver from Rockhampton, who once gave me, a starry-eyed-ball-boy, a dozen signed tennis balls; grumpy Jimmy Connors and of course, the sublime Arthur Ashe who died of AIDS in 1993.

In the past, I have read a few books by physician/authors and have always been deeply affected by them. Many of my doctor friends feel the same way. Perhaps we speak the same language, see the same things, think the same thoughts, and want so much to be better at articulating those things that we feel and see in our everyday work; maybe that's the reason we so admire our colleagues who can put those thoughts and words into story in such compelling ways.

We work and live in the swirl of a 1000 novels; we are surrounded by the best of real life stories. So many in fact, that we cannot embrace them all. For those we do, that needs to be done with our eyes wide open if we are to survive and remain professional and helpful.

In truth, the practice of medicine is a life of self discovery where technical competence is an entry level requirement made all the more valuable by our willingness to learn and improve what we do. However, the ultimate effectiveness of how we use those skills depends on our ability to connect and engage emotionally with people.

That line or the balance between allowing us that right mix of personal protection and distance to be able to do our job, whilst at the same time, allowing us to connect with our patients and their families in truly meaningful ways, will differ from situation to situation and from person to person. What is a comfortable position for some may be intolerable for others. There is no simple answer for us involved in healthcare, no pre-plotted compass to help us out in seeking that balance. It is a line we need to find in each and every interaction we find ourselves in, and a line that we need to advance as we progress through our careers. This is an endeavour that does NOT come easily or naturally to many of us, especially in our fast moving and demanding world.

Doing this successfully is more about sensibility than time; although with time, that sensibility can be developed. The recently deceased Professor of Physiology at Otago University's Medical School, Douglass Taylor spoke about just that to my 2nd year class way back in the last century. For him, reading novels was his salvation from drowning in the sea that is medical training and post-graduate studies and his means to find that very sensibility we are talking about.

Some of us are talented enough to take that sensibility and turn into a force that actively sustains them and others, through the power of the stories they tell. Glenn Colquhoun does that. Glenn is a poet and children's writer, and a GP in the Horowhenua. He is also a South Auckland boy, born and raised in Papatoetoe. He and his family have had a close relationship

with my second home, Middlemore Hospital. “A Middlemore of the Imagination” is the story of the relationship between him his family and our place. You can watch him perform this at the opening of Ko Awatea [here](#) or read it and more in his most recent collection, Jumping Ship.

David Galler

Director of Clinical Leadership

[Ko Awatea](#)

Intensive Care Specialist

Middlemore Hospital

Counties Manukau Health

Jeff Brown's Blog: "Reading Allowed"

By Jeff Brown -
December 15, 2015



15 December 2015: Recall the joy of reading aloud, to a child. Weaving fantasy from the page into their reality with words soft and sweet. Sounds carrying their own meaning, maybe more than the bald story. Not getting away with turning two pages to get to the end too fast. The wonder of discovery at the pace of a rhyme.

Remember growing up to realise you didn't know everything about everything, that you would have to read to learn, to regurgitate. Screeds and screeds. Fast reading. Skimming. Fast enough to disconnect the speaking brain from the scanning brain. Cramming. And always slipping behind the accumulating data of medical progress.

Then as you mature, swimming in the saturated swamp of consultation, over everything, within millimonth timeframes, struggling to have any chance of shifting the system you inhabit.

Oh, the pleasure of spending time with a patient. Of slowing down to listen to their story, to focus on the particular of what matters to them. To calibrate their tale against your held beliefs, our medical myths and shibboleths. To translate your mindmap into their language, to offer hope disguised as miracles. Then listen again to reflect on whether they have truly believed in the magic you have offered.

You have written down their stories in histories. You have recorded your stories in differentials and management plans. You have documented how you have delved deep into their molecules, muscles and mind. And between the cracks you may have discovered again the joy of slow reading, of moving your lips while you savour the story that inspires you to write outside the medical file.

That you may shyly wish to share with this young project that may lead to who knows where. To allow others to read, aloud.

Humbly yours,

Jeff Brown

an Intro by Glenn Colquhoun

By Glenn Colquhoun -
December 23, 2015



Hi everyone – I realised not long ago that I’ve spent nearly 20 years now balancing careers in writing and in medicine. I’m not sure I ever really meant for that to happen. For what it’s worth, for most of that time I haven’t written about medicine – but that hasn’t stopped both disciplines becoming deeply entwined. This project is close to my chest mainly because doctors keep telling me their stories whenever I tell them mine – and I’m struck by just how powerful they are and what they tell us about our patients, ourselves, and the society we live in. The older and uglier I get, the more I keep worrying at the idea that for all that science is the basis of western medicine, I actually live my working life in story. That’s what tells me most about what might be going on with a patient and what might be worth doing about it. I love hearing what you do out there. I learn from it and I’m humbled by it ... so please summon up the courage and write it down for us. We’d love to read it.

Jeff Brown's Blog: "Sharing"

By Jeff Brown -
December 24, 2015



Pohutukawa - New Zealand evergreen Christmas tree. Close-up. Isolated over white.

24 December 2015: Shyly sharing has touched some chords in the hearts of doctors. Stories are arriving from all disciplines, with perspectives on this thrilling calling of ours that show how deeply we are affected by what we do and who we meet. My expectations are already exceeded, and it looks like we may have launched a project that knows no bounds. Spread the word, write the words, and keep sending them to us.

Cheers, and Merry Festivities.

David Galler's Blog: "Mr Cool"

By David Galler -
January 15, 2016



16 February 2016: "Mr Cool" ... It's like living in a sauna but if you stay calm, breath deeply and go slow, it's remarkable how much you can get done before breaking out into a sweat. This is the power of the mind over the body, a complicated set of levers setting balls rolling down ramps, knocking over a series of domino like structures which themselves fan out to knock over others, all to keep control of our pesky physiology by fooling it in to thinking all is cool. Keeping control like this is quite a balancing act, like playing 8 ball pool in the Gluepot or Captain Cook tavern – just enough beer to never miss. One too few, one too many and all hell would break loose.

That's what life's like in the sauna, not the drinking you fool, I'm talking about staying cool. Once you lose it in this place, it's all on and there's no stopping it. Sweat runs down your face like you're in the shower and drip, drip, drips down your back. Once it starts, a new set of mind games begin, necessary to accept that this is what it is. It's a sauna for me and it's the same for everybody else. We all sweat but interestingly we don't smell. Body odour and sweating often go together – but here in this sauna, for everyday people doing everyday things, we don't. Don't ask me why, I don't know, nor do the select group of people I talk to about this strange phenomenon.

At first, taking control in the way that I have described was a tiring and energy-sapping exercise; the degree of concentration necessary to defy the elements and retrain my hypothalamus left little room for much else. It was hard to stay focused on the task at hand and I got little done. As time passed, the obvious energy needed to stay cool in the sauna has diminished substantially and I have become quite functional.

I have come to like the heat, so now, given a choice between the sauna and fridge, I would choose the sauna every time. I am reminded why by many little every day things. Having been previously so useless in the heat, I can now multi-task in a way that has never before been possible in cooler climes; I eat less so friends who haven't seen me for a while say "gee, you look good." I like that. I never ever cut myself shaving no matter how wildly and blindly I

wield the razor, perhaps because my skin is so soft and whilst I'm on the subject of skin, let me tell you that I am now confident enough to wager big that I will never have a facial hick here. That confidence is reinforced by my memories of working in steamy Hong Kong many years ago; never a hick or a shaving nick there. Here in the sauna I wear shorts, without the worry of developing thick thighs to protect me from the cold, always accompanied by a new range of beautifully coloured shirts. For formal occasions I will don my iafataga and feel the breeze in the way women do. What a liberating dress that is and so, so comfortable!

I know, by now you will think I am deadly cool and so in control all of the time; I wish I was! However the truth is that on occasions I reach melting point and boil down. I will let out an inner scream and head for the water. My favourite spot is the blue pool in the back garden with views all round – swaying coconut trees, the big mango trees left and right, laden with fruit at this time of the year, the banana palms and at night, the fruit bats circling over head under the swathe of stars we call the milky way.

Bought in a xmas sale from one of those stores I never go to, that pool has been a lifesaver and in so many ways, a miracle of human ingenuity. How all of it, the huge plastic mat on which it sits, its cover, the pool, the struts, the screws, the ladder, pump and hoses, were squeezed into that box will astound me forever. When it arrived in sauna time last year, transported in the hold of the Southern Lilly, our lives were transformed.

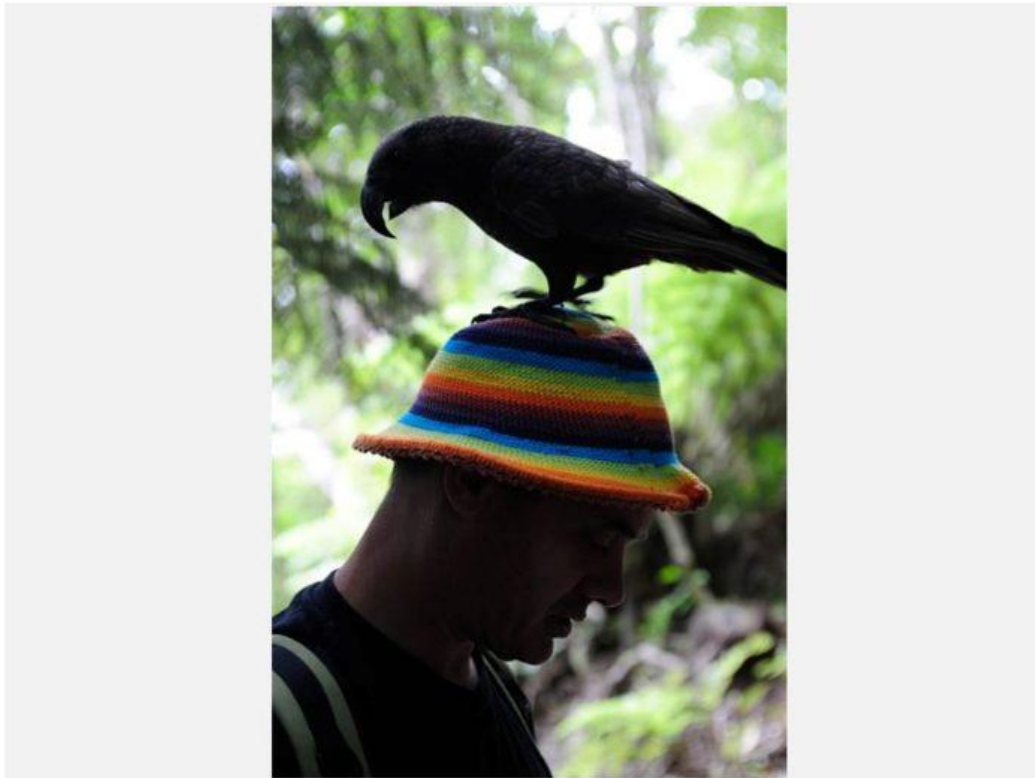
A few years ago I was on holiday in Hanoi during their sauna time. It was 39 all of the time, so hot that occasionally I would totally overheat – my vision would blur and I was overcome with nausea. Sanctuary was an air conditioned taxi or hotel and rehydration with a street side Pho, so full of the electrolytes lost in the heat.

When I was so overcome the first time I was near the magnificent Metropol Hotel, where I was staying so I headed directly to the pool. To my complete surprise, the water was not cold and crisp, it was luke-warm, I cursed. After that first flush of anger it started to make sense. We mainly lose heat through radiation, eh? Dunking into a cold pool after being so hot feels good but like having a cold shower after exercising hard, we might feel cool whilst we are in the water but the veins in our skin have constricted in the cold, limiting the amount of heat lost from our body. Here in the pool at the Metropol, the water was 30 degrees, the veins of my skin still maximally dilated, so heat poured out of me like water pours down a waterfall. Thirty minutes later all was well, Mr Cool was back.

So when that happens here, it's to the blue pool I go, sometimes with a G and T, sometimes with a whiskey and soda, sometimes it's just me, Mr Cool.

Glenn Colquhoun's Blog: "Kia Ora"

By Glenn Colquhoun -
January 18, 2016



18 January 2016: Kia ora everybody – well it is the new year and our website is up and running. Yay! After a flurry of submissions at the end of last year we are steadily catching up to ourselves and settling some new pieces into place.

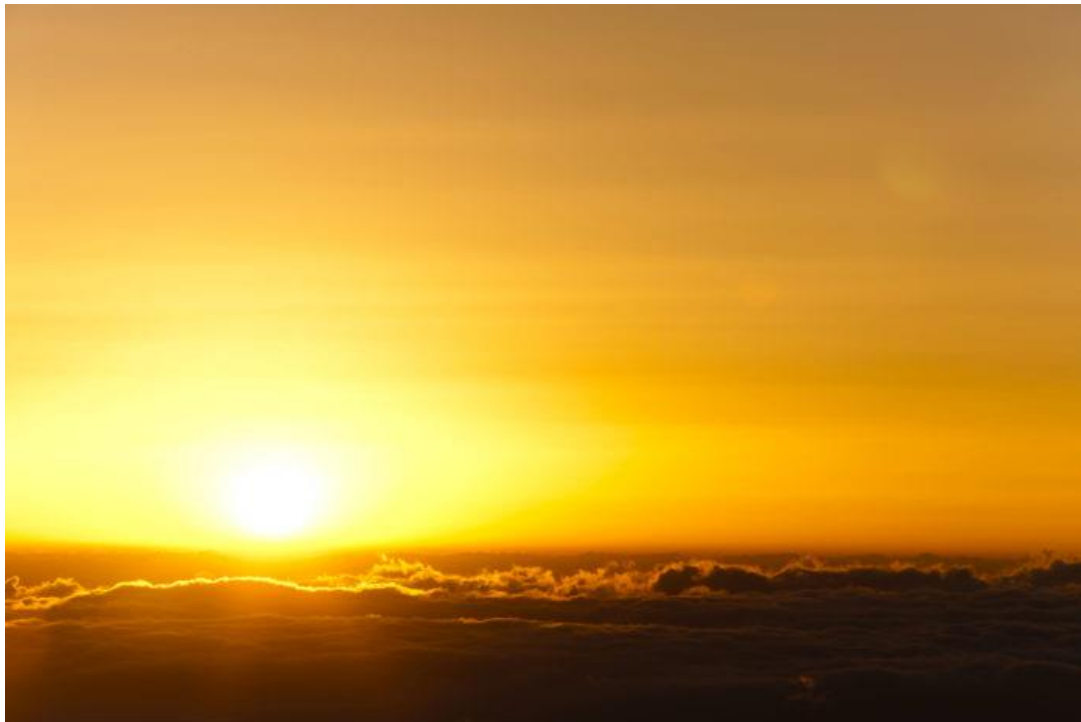
Please take a look at the poems by Art Nahill. We will soon publish some work from Jenni Waddell, as well as stories by Greg Judkins and Trevor Lloyd, they are a fantastic evocation of medicine as it is practiced – with all its push and shove and stillness. We are also getting ready to put up some writing from Sinead Donnelly, a palliative care physician in Wellington hospital, talking about her experiences there – but there is lots of room for more. We have also archived a few more pieces of writing that haven't made it to the website, as everything seems worthy of keeping as a record of what doctors see in their practicing lives.

Hopefully what is written here will stick somewhere when you are consulting, and you will recognise a similar situation when it arrives – or maybe it will inspire you to try and catch that glimpse of something invisible you thought you saw, and get you to pull it out of thin air and tie it to the page flapping. We're hungry for more so have a think about scribbling something for us. We'll do our best to help you take it from there.

Cheers, Glenn.

Jeff Brown's Blog: "Muggy Nights"

By Jeff Brown -
February 9, 2016



09 February 2016: Muggy nights, mozzzy bites. Fright and excite anticipating new classes. Perfect recipe for short fuses in kids and short circuited parents. Add a pinch of vanished January and a measure of cramped forecasts. No wonder the crisis teams are exhausted.

Have you kept your head? Had the time to hold your daughter's hand while greeting her new teacher? Had the heart to hear the replayed chatter of her possible little friends? How do you achieve all that – and care for the crumbling bodies and minds – a new shopping list every 15 minutes?

I would really, really, like to learn from you.

If you have time enough to choose wise words, even a snippet, how about sending a story to us. We can shimmy it to and fro, suggest a bit of polish, sharpen some edginess, and when you are happy, put it up on this website so that others can soften their shoulders by sharing your yoke.

Regards

Jeff

Glenn Colquhoun's Blog: "Doctor in the Mountains"

By Glenn Colquhoun -
February 22, 2016



22 February 2016: Hi everyone, I was wandering through the local market the other day and came across a book called *Doctor in the Mountains*. It is the autobiography of Dr William Anderson and it was published in 1964. It is a memoir of his life working around the Lake Wakatipu district as a GP for the best part of 50 years, and is full of insights that continue to be relevant to being a doctor. I picked it up for \$5.00 and began to realise that there must be dozens of books like this that have been written by NZ doctors over the years. I suspect many have been buried on bookshelves for a long time. It would be great to compile a list of them ... and to try and collect a copy of them where possible, for the library at Ko Awatea. So ... If you know of any please take a moment and send us an email and let us know the title of the book and the author and we can add it to our list. People often remark that medicine and writing are unusual things to combine in a life but I'm not so sure ... I'd guess there is a great number of doctors who have written about their experiences in medicine. Anyway, scratch your heads and check the bookshelves and let us know what's out there.

In the meantime thanks to those who have sent writing in so far to The Medicine Stories Project. Our small website is starting to stretch and grow, and there is some great writing lining up in the wings to go up over the next few weeks. We'd love to hear your stories so please take some time when you can, and consider scratching something out for us.

David Galler & Glenn Colquhoun's joint Blog: "Malo"

By Glenn Colquhoun -
April 18, 2016



18 April 2016: Hi everyone,

It always strikes me what a broad church medicine is. In many ways it seems a career full of careers. What a doctor does on any given day can range from dissecting a body to talking to a teenager about what is going on at school. It also varies greatly in the locations it is practiced in, from purpose-built Auckland bunkers where everyone is dressed in green to the lounge room of an old farm house in the far reaches of Southland.

A while ago Dave Galler and I hatched a plan to capture what is similar in what we do in the middle of what is very different. We decided to write to each other every night for one working week and talk about our days. Dave is an intensive care specialist. At the time we wrote he was in his last week of a year away working at Tupua Tamasese Meaole hospital in Samoa. He has since returned to Middlemore. I work as a GP in a youth health clinic in Horowhenua.

When the time came both of us thought we had better things to do but by the time we got to the end of the week it seemed strange not to hear from each other. We wanted to find out how those patients the other was seeing were doing – a testament to the power of narrative to draw us in.

We've published the emails below. We'd love to hear something similar from any of you who want to record the cut and thrust of a single day in medicine. It occurs to me the simple record of a working day from doctors throughout the country would be a great way to catch the variety in what we see and do.

Hope you enjoy the yarning.

Cheers,

Glenn and Dave

Subject: Malo

From: Glenn Colquhoun

Sent: Monday 22 February 2016 10:50 PM NZDT

To: David Galler

Subject: Malo

Hey Dave,

Well mate, it's going on 11.00 pm and I'm sitting down to go through the day. I don't want to but I promised. And there seems something to be gained by it. It's been long and varied and is coming back to me in pieces.

The girl who lived on the streets for a while and her smile and her gorgeous baby boy. She can't believe she might just be safe and warm and worth something.

The young man with fetal alcohol spectrum disorder and the circle of papers and definitions that swirl around him. I've promised him a banana cake. Small compensation for the systemic mountain we've asked him to climb to prove himself to us. Christ we can be bastards with all our processes sometimes. They are a safe meanness.

Then there is the young man tripping along the edge of renal failure after a lifetime of nephrotic syndrome. What a great soul. At 18. Goodness is a thing man. Palpable at times.

Another young mum struggling. Old ghosts. The usual. Trying to run on a broken leg.

My awesome young guy with dripping ears who only gets his meds half the time and only takes them half the time and never makes an appointment. But he's on the upward curve, Dave. Life is bursting out of him. You can't stop it. God I wish him well.

Tonight a peer support meeting and my daughter's homework. A text about a boy who won't come out of his room and one with a headache. A girl with a boil.

You might see any one of them at your place on any given day. Fights gone wrong. Drugs gone wrong. Bodies gone wrong. Cars gone wrong. At least three of them have nearly died already.

Oh and by the way ... ACC wants me to re-refer a girl with a slice of skull missing after an MVA to a head injury specialist who is seeing her anyway ... they know that ... but want to make sure I think she still needs to be seen. Are these people mad? YES THEY ARE!

Good to talk brother.

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Cheers, Glenn.

From: Dave Galler

Date: Tuesday 23 February 2016 05:07 AM NZDT

To: Glenn Colquhoun

Subject: Malo

Malo Glenn,

The air here is still and heavy today – thick with moisture and a heat I can feel as it makes its way down into my chest – I can't help but think that this is what it must be like to be on CPAP.

The ICU is full, most people getting better apart from one who we could never help – he is a 'medical outlier,' youngish but already on his way out.

Junior, a sweet 6 monther, has finally started to absorb his feed – amazing really after four big operations in 10 days, starting with a mean intussusception. He's lost a major part of his small intestine and dropped his weight from 9 to 7.2kg. Maybe, maybe, he will get better.

The baby in the next bed, Sauscisi, I call him, is the same age but twice the weight. A monster child, with a head round as a football. He is still ventilated, his neck opened from ear to ear to drain a horrible deep tissue infection. He is off his inotropes and his renal failure resolving. He should do well in the short term, but managing that wound will be hard here – maybe a skin graft to start with, then a battle to avoid contractures.

The third kid, I call him Mobutu, has been with us in the ICU six times already and he's only 11 months old. He's the last of nine children. Each time he presents the same way, with a worsening of his persistent stridor and then heart failure. Each time he has responded well to being ventilated and diuresed, and then is easily extubated and each time he is sent back to the ward on captopril and spironolactone and then home. It's hard here, we can't find the cause and we hope he will soon go to NZ to be properly assessed. He is a resilient little guy – I say little because he is undernourished and perhaps a little syndromic. This morning after being extubated, he did what he always does, sat up in bed and threw a minor tantrum, demanding food. When he does this he reminds me of one of those mad African dictators; all that's missing is the leopard skin cloak.

Opposite him is Lanu, looking comfortable and serene. She is young and has been in the ICU for 42 days with Guillain Barre. She is in perfect nick thanks largely to her family. They have turned her and massaged her and rubbed her with lotions and potions. Each day I chart that on the daily plan – fofo and massage Q 4H.

That was my morning, Glenn – then I started gathering up things and putting them in boxes – recycled ones, mostly those that did the journey from Auckland to Apia exactly one year ago, nestled in the hold of the *Southern Lilly*. Those boxes will soon be back on the *Lilly* for

the journey home and with their contents somewhat changed; a range of new shirts, fine mats, wooden weapons, several Tanoa and more.

I did this gathering and sorting and packing all afternoon and into the early evening, then I made okra, drank water and went to bed.

From: Glenn Colquhoun

Sent: Tuesday 23 February 2016 11:34 PM NZDT

To: David Galler

Subject: Re: Malo

I loved reading your cases, Dave. It strikes me bodies are stories in themselves. Every one has its own narrative. Every illness is the same. Doctors and families have them as well and when we practice all these arcs start interweaving and overlapping. Medicine so quickly leaves science behind in its practice and becomes an art ... a balancing act.

I had a school clinic this morning. And then helped launch a poetry anthology in the afternoon. I've got some pieces in it about Ernst Dieffenbach. Probably the first doctor in New Zealand to write about what he did here. He trained in medicine but came out to NZ on the Tory in 1839 as a scientist. He gave the name greywacke to the rock that forms the backbone of the country and was the first European to climb Taranaki. He wrote a grammar of Te Reo Maori and lent his name to the Chatham Island rail – which is now extinct.

He also kept a pet weka.

He didn't practice medicine much but got roped into helping the ship's surgeons at the battle of Kuititanga fought out at the Waikanae rivermouth between Te Ati Awa and Ngati Raukawa in 1839. I came across him when I worked as a GP for Te Ati Awa and ate lunch every day on that beach. I realised he would have tended the ancestors of patients I was looking after at the time.

Remarkable how we tangle. We have looked after the same skin. I had to sing him some songs after that. I'll warble one for you when I see you next.

Go well brother.

Must be bittersweet packing up.

We're losing the cricket.

Bring me a shirt!

Cheers, Glenn.

From: Dave Galler

Date: Wednesday 24 February 2016 5:31 AM NZDT

To: Glenn Colquhoun

Subject: Malo

Malo soifua hombre.

Haha.

I will bring you a shirt.

Where is that dude buried?

We should go visit him.

Groundhog day, Glenn!

This morning I was woken early by the rooster in the lime tree out back. That hasn't happened for a while. When we first got here they drove me mad, so mad I complained to Assi, our landlord and Flori, his Annie-get-your-gun daughter. Things improved after that, Flori shot a few and I started to use the air con to baffle their sound. This morning I did what I did in those early days when I first got here, I got out of bed and pelted the tree where they roost with rock sized limes and sent the bugger flying off to another patch.

I could have done with more sleep but I like the early morning – the sun was not quite up but it was getting light. In the air you could hear but not see the thousands of buzzing insects hovering 30-40 feet above the ground; the sound is amazing.

Not long after I started here, the NHS gave me a truck to use; a green Hilux with bald tires and no mod cons apart from good air-conditioning and a basic radio. I love it, being up high cruising through the back roads from Ululoloa to Moto'otua, past the plantations and through the little villages. At that time of the morning there are more dogs than people on the road but by 0745 the kids start drifting out filling the old buses each with its own name – Heavenly Peace; For the Grace of God; Forever Free; Poetry in Motion; and my favourite, Paradise in Heaven.

The African tyrant went to the ward in the middle of the day.

Lanu did the whole day on a T-piece.

The charge nurse pulled the chublet's central line out by mistake – it took days to get in. I gave a Homer Simpson 'Doh' and we laughed then cried.

I met the Faculty of Medicine people at the University of Samoa in the middle of the day. They want to establish a Masters of Medicine programme and shift the training from Fiji, where currently Samoan post grad docs go for years to be used like the Fijians used the Indians in the sugar cane fields.

Later as the heavens broke I steered my green Hilux through streets that quickly become streams and rivers to see Tifitifi, the boss at the government print office – she’s cool. We’re out of 24 hour charts and needed more.

Just as I was planning to leave TTM (Tupua Tamasese Meaole Hospital) we were called to another sick kid on the ward – more of what we have seen before – and too often presented at mortality meetings. A girl of 12 who had been unwell for over a week – vomiting, diarrhoea, myalgia and joint aches. It’s labeled as Dengue here but to me it’s always staph or strep till proven otherwise and if you think staph it will be MRSA. Now she’s sick as, delirious with a hot swollen arm and elbow and looking dreadful. Hypotensive tachypnoeic, sore everywhere, no murmurs yet ... she’s been in two days and if that’s not what she’s got then I’m the Pope.

My crew is good now. They know the routine, they recognise the pattern. Full bore organ support and off to the theatre. They are good and they love it, so we talked it through and I left for home. More packing after that ... and a Thai beef salad. I had a whiskey too ... then crashed.

Four more sleeps... Talk soon, uh!

Soifua from the sauna.

From: Glenn Colquhoun

Sent: Thursday 25 February 2016 00:45 AM NZDT

To: David Galler

Subject: Malo

He’s buried somewhere in Geissen, just north of Frankfurt, Dave. I walked the old university graveyard there a few years ago trying to find him. He was the professor of Geology when he died. Of Typhus. Out of the blue ... unready and unfinished.

I turned up a blank, but found Roentgen instead – the guy who discovered x-rays.

I’ve been in clinics all day today. And finally found someone to help my boy with fetal alcohol spectrum disorder. I trawled the service directories and made heaps of calls. I had a long conversation by txt with a 16 year old who is due to have a baby soon and has found some peace and kindness with her boyfriend’s parents. Her mum has too many old griefs. My mum is knitting for her.

I put in a jabelle and read some old notes about a patient who has been hypothyroid. I asked the ortho reg about fixed flexion deformities. He wasn’t that interested.

I listened to a young woman who has lost her dad and whose mum yells and whose boyfriend yells. Remarkably she is full of joy. As though despite everything it has been born into her. Her boss loves her. Her customers love her. But she is sad too. Sad and full of joy at the same time.

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I listened to another young woman who worries. I don't think I helped at all. I am still running the consultation over in my head. Did I say too much? Did I say too much? I said too much.

Some kids don't come so I yak to the nurse. She is a treasure.

I tracked down a kid I think the world of. We have worked with her for a long time. She has been poised between the light and dark for as long as I have known her, but I feel her slipping into the dark now. I think her drug use is escalating. We are supposed to catch up tomorrow but we'll see. I don't know what to say to her if she does rock up. 'Stay in the light,' perhaps.

Medicine made me grumpy for a long time when I first began to practice it ... then once I'd survived long enough it made me kind again. Something had to be broken in me first I think. That's been one of its gifts. Kindness is underrated in medicine. It is unmistakable in the eyes and in the hands and in the pause and in the voice.

I can see it in you, Dave, and admire it.

I'd love you to meet the kids sometime.

Cheers, Glenn.

From: Dave Galler

Date: Thursday 25 February 2016 10:31 AM NZDT

To: Glenn Colquhoun

Subject: Malo

Hey brother.

It's been pissing down here – a deluge of water pouring down streets and turning them into rivers – cars almost surfing down the streets.

I started early today – a quick ward round at 0700 then a series of meetings and lunches and finally a big dinner with the NHS Board and the Minister of Health and his fabulous wife – a dinner to thank me for my work here and a request to my organisation to support me coming back here once a month for a week to carry that on and move into other areas of improvement.

Also a chance for the government and PM to thank me too!

It was a little overwhelming, but really moving and affirming. There is a grace and ease about the people here that is simply beautiful – they are welcoming and they are funny and I can feel their embrace wherever I go. In the supermarket, on the street, people know who I am and they thank me for the work we are doing here.

The patients are doing ok, too. The baby with the intussusception will go to a ward today.

Ana the 11 year old with staph sepsis has osteomyelitis of her L humerus and pus in her L elbow and shoulder – more too in her L hip and gluteal muscle. She will go back to the OR today but she is reasonably stable on a sniff of noradrenaline – on CPAP now despite her CXR still showing lungs full of staph fluff balls.

Lanu with GBS did 10 hours of a T piece and today will be 12. Our plan is to extubate her over the weekend or Monday if all goes well – it's more a matter of her confidence now than anything else – her skin is still perfect after 45 days!

Saucisi, the chublet might be extubated too – but in theatre. His neck wound will likely need a graft – James Hamill from the SS will be here next week – he might do it.

Three more sleeps; three more evenings of farewells. Tonight at La Manumea with the crew from the ICU – that will be quite special I know and very disconcerting for all of us too. Tomorrow morning Ema's last and very symbolic sitting in the Supreme Court of Samoa. In the evening the official farewell to her from the Ministry of Justice and Courts Administration.

Saturday at HOME CAFÉ with friends for burgers chips and beer....

It's momentous Glenn.

Talk tomorrow my friend.

Have a good one.

From: Glenn Colquhoun

Date: Thursday 25 February 2016 11:31 PM NZDT

To: Dave Galler

Subject: Malo

Oh Dave ... That's fabulous man. You and Ema both deserve the congratulations you are receiving. And I so hope you get to carry on what you're doing there. I'm glad the tide is coming in again on all those small ones ... And it strikes me that they are all small.

Our young people's demons are very different.

I hardly ever pull out my guns. My job has become so much about talking and listening and liking. I think I say 'awesome' more than anything else. And yet that somehow seems pretty important.

The things that bedevil here are broken families and communities. We are poorer I think despite our wealth.

Today we cooked at the alternative education school. We started a class a couple of years back. The kids have been excluded from the high schools in the area and bounce and bounce. Every one of them has a story and everyone of them is at risk. I have long figured I can be of more use beside them than in front of them.

We usually cook a big feed for lunch. They prepare the table and the meal. They are remarkably kind and generous and understand aroha. Which is not to say they can't snap into blind rage and lash about indiscriminately. We made chow mien and two banana cakes today. One for them and the other for my young man with FASD.

I was worried he didn't have anything to keep it in but he said he would eat it all tonight and I suspect he might. God, there is such goodness in his grandma. She was with him again today for an appointment at WINZ but they couriered a change of appointment to him this morning which arrived two hours after the new time they had given him – then blamed him for missing it. She was at a loss. Systems are so cruel. They are never a substitute for people.

My girl didn't show up. She rang impossibly late and asked for everything over the phone. I held out and fitted her in on Monday. I told her I felt like she is slipping away under the water.

Someone wanted to know if a protein shake would interfere with their meds.

I completed an application to the council for some money to buy food for our cooking programme.

I saw a young man with a nasty virus and a young girl down the road with chest pain who wandered over after tea. I've watched her grow up.

I'm melancholy tonight. A good space to write poetry in. The weather has been gloomy and the salt is all over the windows again. It is cooler. Autumnal. And the days are wearing out just that bit sooner.

The whole thing is going round again.

Catch you on the other side.

Tofa soifua,

Glenn.

From: Dave Galler

Date: Friday 26 February 2016 11:26 PM NZDT

To: Glenn Colquhoun

Subject: Malo

It does go round and round. I think you need to be of a certain age to clock that. A year older again, and another year faster than the year before. I am certain of that.

I was woken up again this morning. It was still dark with nothing much to hear apart from a distant rooster. Rude animals eh? Best broiled.

And now I have a headache. An accumulation of late nights as well. A farewell at La Manumea with the ICU crew that was so touching and sad and happy and which made us all cry. A huge photo board of the year with friends at work, patients we've treated, families we've helped, parties we've all been too. They will miss me – and I will miss them.

It's been a hell of a week – so full of emotion. I feel as though great chunks of me are still in various parts of Samoa, stuck to places and people – in their hearts, and theirs in mine. Aeroplanes and modern technology are cruel and leave little time to adjust – maybe we should have come back in a waka or a slightly bigger ship with more time to grieve.

Today saw my last ward round – hugs and kisses all round and messages of thanks from every person I met. I have been blessed a 1000 times over and I am a happy man for that Glenn.

I left my latest group of patients in a good state.

Lanu had her tracheostomy tube removed and is thrilled – so are we. She is good and still smiles the same beautiful smile. Nothing like getting better to make you feel better.

My 11 year old girl with staph sepsis has been extubated, her fever has settled and her noradrenaline is off.

The chublet, aka Sauscisi, who has Staph as well (but one only sensitive to Chloramphenicol) is also good. He is extubated, feeding and ready for grafting late this week.

Junior, with the short gut and ileostomy, is doing ok but I'm not sure whether he will have enough gut left to survive and grow.

Last Sunday we cruised Upolo in Ema's Hilux. Sunday is a smoky day as families rise early to prepare the umu for the family lunch. We passed people dressed in white on their way to and from church. They waved and smiled and posed for photographs. We passed open fale with families snoozing in the heat, avoiding pigs and piglets, chickens and their chicks, crossing the road till we got tired and felt like a sleep ourselves.

I love Samoa and I love the people and their culture and tradition.

I love their love of God.

We have been touched my friend, truly touched.

We will cry when we leave – that's as it should be.

I wish I could sing but I can't.

I wish I could play an instrument but I can't.

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I march to the beat to my own rhythm – but no-one else does.

Weird uh?!

I will keep saying uh because it's Samoan and I am part Samoan now.

Love to you and yours, HOMBRE.

xxxx

From: Glenn Colquhoun

Sent: Monday 1 March 2016 8:35 PM NZDT

To: David Galler

Subject: Malo

What a blessed week to share with you man. I read back over where we started from. It helps to feel witnessed – and to witness in some way.

The world has turned by a week but I could start all over again and tell you the same different stories.

Today I listened to a girl tell me about her mother screaming at her all her life and to another tell me about being raped by her friend's brother. Three boys from the alternative education school made quick work of the lolly jar. How gentle the angry ones are. My lad with FASD has taken the cake. Disability services are still refusing to accept his case and his grandmother continues to drive 100 kms every day to see him. She is my New Zealander of the year. My boy with nephrotic syndrome has a creatinine in the hundreds again and is in hospital.

My girl who doesn't show up didn't show up.

It's been good to think about what we have written to each other. The different fates of the young in Samoa and New Zealand. The horror of infectious disease. The horror of social dislocation.

I keep coming back to the tenderness in what we do. It seems woven throughout. And I am stuck on how to write about this properly. But it feels like I love my kids. And that you love yours. It is palpable to me. And yet as a doctor that seems such a dangerous thing to say – as though it could easily get mixed up or messed up. And I am so extraordinarily cautious because I'm old now and have seen that hurt. And I am keen to avoid the old cliché of it as well ... but as much as I try to avoid it that is what it feels like. Aroha. Regard. Care. Sometimes it literally is all I have to offer my patients. Kindness. Their circumstances are so ensnared and they are so socially and psychologically and economically stuck that you can but wish for them. And the care wounds and costs and gives back at the same time so that I feel continually tipped upside down and shaken out every day then filled up to bursting again by the time I leave.

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I feel like I have read a novel every time I get home at the end of the day and in a way I have. The thing is I could easily miss all this by just not looking and do much the same medicine. I have after all for years. But when I choose to practice with my eyes open the tenderness is overwhelming.

You are an old robber Dave, I have such respect. And I love it that you are capable of being wounded by what you do and that you are still angry and that above all that you are kind. I'm struck by the fact that we are old outsiders too – Jews and Seventh-day Adventists – Saturday keepers – I suspect that's important somewhere in the whole scheme of things. The bloody gods. But then again we are all local eventually.

I am buoyed by the fact that Samoa's loss is once again South Auckland's gain. She is a mighty old city to come home too – rambling and joyful and lost and found. She is in anguish too. Kindness won't go astray there.

It will be good to see you.

Thanks for the yarn, brother.

Go well on the great seas.

You with your children.

And me with mine.

Drag them from the water.

By the hair,

by the head,

by the arm and leg.

There, at their ends,

find yourself, bedraggled.

Stand up then.

Suck in the air.

Let it fill up your lungs.

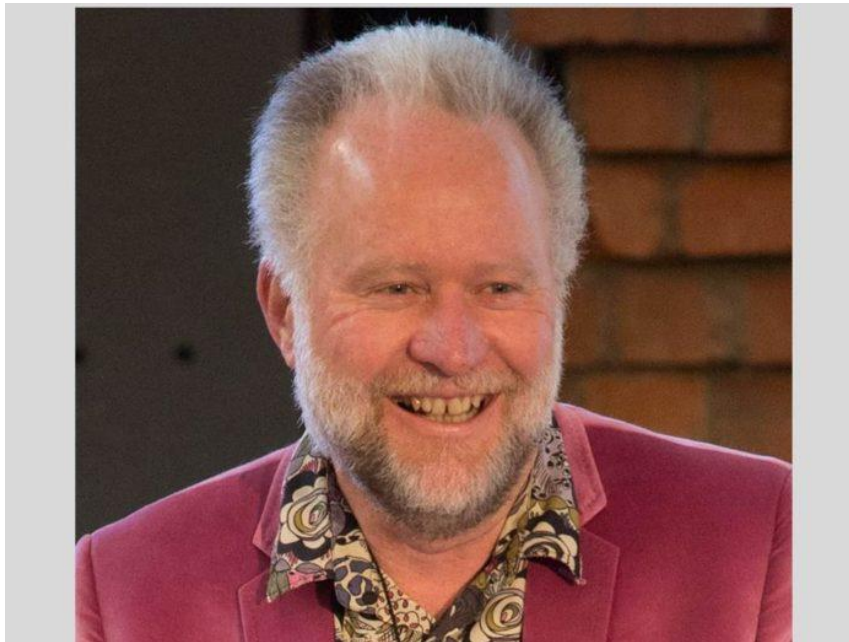
We rescue ourselves.

Cheers, Glenn.

Cheers, Glenn.

Jeff Brown's Blog: "Rhymes with Rio"

By Jeff Brown -
June 20, 2016



20 June 2016: Rhymes with Rio

Germany topped the Olympic medals table in Fine Arts between 1912 and 1948. Medals were awarded in architecture (including town planning), literature (dramatic, epic, lyric categories), music, painting, and sculpture.

The Paris Olympiad in 1924 had 193 submissions, which included three Soviets, even though officially the USSR did not take part in such a bourgeois festival. Over 1,100 works of art were exhibited in the Amsterdam Olympics in 1928, plus literature, music and architecture offerings. Artists and others were encouraged to sell their works at the end of the Olympics. Because of distance and recession there were fewer athletes at Los Angeles in 1932, but the art exhibition attracted 384,000 visitors. In 1936 the USA won silver for town planning, losing out to the German, Werner March, who won gold for designing the Olympic Stadium in Berlin.

Avery Brundige, head of IOC, was concerned that winners of Fine Arts medals were professionals, would capitalise on their accolades, and thus undermine the amateur spirit of the Games, so at a meeting in 1949 the IOC decided to abolish the Fine Arts medals. Heated debate led to reinstatement for Helsinki in 1952, but too late to invite submissions, so an art exhibition was held instead. Subsequent Olympics have held concurrent exhibitions. Meanwhile, athletes have become overt professionals, have profited from their Olympic successes, and have been able to sell themselves before and after the end of the Games.

There are just two individuals who have won both sport and art medals, while the oldest Olympic medalist remains 73 year old John Copley, who won silver in 1948 for engravings and etchings.

Old or not old, sporty or couchy, why not send your fine art jottings, poetic or prosaic, to our Medicine Stories Project for others to enjoy during the 2016 Olympiad. Save yourself from zika, from training for stadium podium, from testing for performance enhancement, and put pen to e-paper (or other forms) to tell us your story. We accept, without urine or blood testing, without A or B criteria, without high performance camps, without missions or chefs, any contribution from your rich tapestry of medical life.

Whether or not it rhymes with Rio.

Regards, Jeff

Glenn Colquhoun's Blog: "London wanderings"

By Glenn Colquhoun -
June 20, 2016



20 June 2016

I was in London last week for a friend's wedding, which gave me some time to wander. I ended up going to have a look at the Wellcome collection in Euston Rd. It is a library, museum and art gallery that was set up with funding from the estate of Sir Henry Wellcome, an early pharmacist and philanthropist, who acquired a large collection of medical memorabilia.

It was a fascinating experience and underscored again the value of standing back and looking at our profession from a distance. It was great to see amulets and iron chastity belts, Napoleon's toothbrush and old surgical saws all juxtaposed. What really drew me in though was a permanent exhibition called 'Medicine now.' It explored a number of issues in medicine and invited artistic responses to those. I was struck by an all-white library stack full of plain white books that reached from the floor to the ceiling. It contained a printout of the entire human genome. There was also elaborate glass blowing of an HIV virus, which made something beautiful out of something that is usually associated with the opposite within medicine. If you are ever in London it is well worth a visit and if not then you can always take a look on the website at www.wellcomecollection.org. I'd love to see something similar in New Zealand one day.

Brad Novak is a public health physician with a successful career as a visual artist. And many of you will have heard of Chris Reid's book, *Patient*, which contains a selection of beautifully captured photographs of his patients. Both of them are preparing something for the MSP website as well. I always think that writing and the visual arts are joined at the hip; they share some sort of evolutionary ancestor of the imagination, as does science itself. So don't be put off if you also work the visual arts and want to send some of your work into the MSP. Painting, drawing, sculpture, graphic design, installation are all ways of telling stories. We'd love to have a look at what you do.

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Regards;

Glenn

David Galler's Blog: "A Great Day at Work"

By David Galler -
June 29, 2016



29 June 2016: In this series of short stories from, and of, the B seat, the author recalls events from a lifetime of travel...

Knowing I needed to be up early, I'd slept badly; it's always that way with me. My head heavy, I had spent the night tossing and turning, buffeted by long lists of things I had forgotten to do, things I wanted to do, and brilliant ideas about stuff I didn't want to forget. It was cold and dark and rain was falling. The taxi was late and the agency had booked me on a budget carrier, to save money at my expense.

On the plane, the rows of seats were even closer together than normal, with the B seat already occupied by an enormous man slumped forward and snoring loudly. He woke briefly as I pushed parts of him across the boundary from C to B, before he lost consciousness again. He smelled, that man – an acrid and quite sickening smell; and he radiated heat too.

Déjà vu, déjà vu, déjà vu I thought, remembering another time when the glamour of travel and my "love for the job" were most sorely tested. That was several years ago when, at short notice, I was sent to the deep south by the Minister of Health to deliver a message of admonition to the then Chair of the Board.

That day also started early in the cold dark-before-dawn, and was preceded by another bad night's sleep. No fat man then, instead stormy weather was sweeping across the country from the south with such ferocity that the plane bucked and lurched like a rodeo beast, prompting the pilot to tell us to "hold onto your hats". The woman in the window seat grew progressively pale then vomited, and out of the stunned silence I could hear the occasional sound of other passengers retching. When we landed there was applause – all right for them but I was due to go on to Invercargill, not in this big animal of a plane but in something

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smaller and thinner, more akin to a flying pencil. To my horror and disappointment that flight was not cancelled but seriously delayed so, many hours later, go on I did; another gut-wrenching ride through turbulent air, finishing with a terrifying descent onto a tarmac covered in hailstones and swept by bursts of horizontal sleet.

The Board Chair turned out to be a proud self-made Southland man, not someone to take a telling-off lying down. Already late in the day, our conversation was civil, short and blunt and soon after, somewhat chastened by the experience and the persistence of the appalling and gloomy weather, I began my journey back to Wellington. Hurtling through space in the pitch-black sky, the plane was struck by lightning – with a loud cracking sound and flickering lights, we spun sideways and dropped a few hundred feet. Holding firmly onto his hat, the pilot wrestled back control and landed us at Christchurch. It was 7pm, the airport was almost deserted and it was freezing cold. Hours later, my onward flight to Wellington was finally cancelled so, furious and completely wrung out, I made for a nearby hotel desperate to lie down and get some sleep. The room was quiet and potentially welcoming, but OMG when I pulled back the bed covers, remnants of a previous guest remained strewn across the sheets ...

Well, that was my great day at work – How was yours?

Write in, let us all know.

Regards;

David

David Galler's Blog: "Lean on Me"

By David Galler -
July 28, 2016



28 July 2016: Swallow Your Pride – Lean On Me. I love my job as an intensivist at Middlemore, but there are times when it can be particularly grim. One of those was a few weekends ago. I was down in the ED seeing a patient, when I heard the screams of a distraught mother as she ran into the department with her child, lifeless in her arms. He had been run over in a driveway and had the signs of that all too evident across his face.

By the time we arrived in the resus room, his pupils were already fixed and dilated; he had stopped breathing and lost his cardiac output. His circulation came back fast with CPR, intubation, oxygen and fluids delivered through two interosseous needles, but with that came torrential bleeding from his mid-face. Despite all we did he died a short time later in the operating theatres.

The horror of experiences like this are visited most cruelly on the family but also in different ways on our people working in the emergency services in our communities and hospitals.

For us, doing our best to resuscitate and stabilise the patient, from the moment we stop our efforts to continue active resuscitation in events like the one described above, the air becomes thick with a pervading emotion. It is hard to find the right word to describe that, but for me “DISTRESS”, comes close. A disturbing and corrosive feeling of a continual and changing upset, a feeling that can last for ages and make us doubt ourselves, our colleagues and our team.

“Distress” is like energy in an isolated system; it is a force that cannot be created or destroyed, only converted from one form to another. It must therefore be dealt with in one way or another, either consciously or subconsciously, ultimately making us better and stronger in how we live our lives or in ways that can slowly corrode us. That corrosion is like rust slowly eating away at our metal, but more insidious and less obviously coloured.

It plays out in different ways in different people: commonly through a loss of confidence, an ongoing blunting of our *joie de vivre* and sullenness more often noticed by our families than

our work colleagues. Not addressed, it turns us into different people and sometimes, simply kills us.

Life is hard enough without this additional burden, so my message to you, my colleague, is to reflect on this aspect of the great work we do and to think whether it's appropriate to be more organised in how we address this ongoing workplace danger.

Many departments and institutions have established formal ways to talk about these issues, commonly beginning with a de-brief of a particularly gory or upsetting incident or case, and reviewing the way it was managed and how we all coped. In many organisations, individual members of staff have access to more professional help should they wish to take that up. My enquiries and experience suggest that most don't!

A few years ago now, I was thinking about all of this when I went to see "Twenty Feet From Stardom" at the International Film Festival and was blown away listening to Darlene Love, singing Lean on Me.

For me, this is a "must see" because it will make you feel good about the world and the brilliance, talent, and creativity that lives there. It makes me feel good about myself and get ready; it made me feel good about you too!

So I say, swallow your pride, let's lean on each other.

The Film Festival is back again – a winter warmer, it is stuffed full of stories and drama, sadness and joy – a best bet to teach us more about how to capture and hold the joy in our lives. See a film, write a review and send to us at the Medicine Writing Project.

regards, David.

David Galler's Blog: "Genko Tree"

By David Galler -
August 1, 2016



We are deep into winter and in my garden the Genko tree has finally let go of all of its leaves. This the most stubborn of trees, only relents long after all its deciduous mates, and always in the middle of the annual rugby extravaganza, whether it be the All Blacks playing the Aussies and the Springboks, or as has just finished now, against a northern hemisphere team, this year Wales.

To be honest, I am a fair weather rugby fan – I occasionally go when it's not raining, but more often I'll be watching from the comfort of someone else's lounge with a group of rowdy friends. I usually like it when we win and see losses as an omen of things to come.

Having watched dozens and dozens of test matches over the years, I now think of myself as a minor scholar of the game; having played it once upon a time, one year, famously moving from the dangerous position of hooker in a social team to a daring role as full back for the Wellington College first fifteen and subsequently a Victoria University team. I eventually gave up when I realised that every time I got the ball, there were 15 people from the other side trying to kill me.

By that time I had learned to read the game and see in it many things that have helped me in my subsequent career in healthcare. Perhaps the most stunning example of that was from what happened in that famous Bledisloe Cup match between the All Blacks and Australia in Sydney, in 1994. You remember the one, when in the last minute of the game, Jeff Wilson, the All Black wing, dived over in the corner for what would have been a remarkable come from behind last gasp victory if not for the tackle of George Gregan, the Wallabies halfback, who dislodged the ball from Wilson's arms as he crossed the line.

Fast forward to Jönköping County in Sweden 17 years later to a time when I was visiting my good friend Goran Henriks, head of healthcare innovation for Jönköping (phonetically: Yonchirping) in Sweden. On all measures, and there are a lot, spanning activity from the home to the hospital, Jönköping County has been the best performing county in Sweden and arguably one of the best health systems in the world; and every year they seem to get better.

Goran and I were out for dinner one evening when I told him about that famous test match and its relevance to healthcare improvement. This is the story.

I remembered it as the last match in the Bledisloe Cup series of 1994 and the last test match for the coach Laurie Mains, a former All Black himself. Things went badly wrong for the ABs right from the kick off with Tim Horan, the Wallabies' centre, scoring a try in the first minute. As the first half progressed so too did the score against us mount. The Wallabies, on a roll, and the All Blacks dour, unimaginative and out-played, went to the half time break, Australia 20 – NZ 0.

The second half was a different affair, as different as day and night and black and white. The All Blacks, who in the first half seemed to be physically weighed down and completely unable to adjust and adapt to counter the Wallabies' onslaught, did just that. Seemingly now unburdened, agile and confident, with nothing to lose and everything to play for, they displayed a form of daring and running rugby that we have now come to expect every time.

Well, back then in 1994, we were all on the edge of our seats as we ran in tries and scored penalties, only to have a last minute victory denied by that brilliant tackle by George Gregan knocking the ball loose from Jeff Wilson's arms as he dived over the try line. Perhaps that's what most people will remember about that game but it came at the end of what must be one of the most remarkable reversals in form ever seen.

So, what happened at half time that led to such a dramatic improvement?

In short, here's what I told Goran:

It was shockingly obvious to coach Laurie Mains, formerly a toe-hacking fullback and a conservative man by nature, that the approach the All Blacks took in the first half of the match was not working and that a fundamental change was needed if the match and their collective reputation was to be preserved. Maybe back then, in his heart, he knew what Paul Bataalden has always been attributed as saying: "The system is perfectly designed to get the results it always gets".

"Boys", he said, "if we want to win (aka: agree and achieve our some by when goal) we need do something different; you know the rules of the game (aka: we work within a set of constraints – money, people, regulations, professional boundaries, etc.); you are the best we have, you have the skills and you trust and know each other well (teams of expert frontline staff doing their work everyday); back yourselves boys, go out and have some fun, go out and win". Well they almost did.

This analogy between sport and healthcare improvement seemed to amuse Goran; an increasingly big smile spread across his handsome face as he told me that he was in fact the coach of the Swedish Men's Basketball team.

A more gracious and wise man you will never meet. Goran Henriks is speaking at the APAC Forum in Sydney from September 12-14 apacforum.com. I know that he will be pleased to shoot some hoops with you , so register now and I will arrange for that to happen.

– **David Galler**

Glenn Colquhoun's Blog: "Lament for a Teacher"

By Glenn Colquhoun -
October 6, 2016

A few months ago I attended a memorial service for Professor Sir John Scott at St Mary's Cathedral in Auckland. He was an old teacher of mine and someone who very much inspired me in medicine. He taught me in clinical methods at Middlemore Hospital, and I was later attached to his team on my fifth year medical run at the same hospital. He always seemed to have so much time when he was with patients. Seeing him take a history or examine a patient was like watching Martin Crowe bat. He was a calm centre in the hurly burly of the consultation. I think now that that was a medicine in itself. When I heard that he had died I wrote a *waiatatangi* or lament for him. It seemed the right way to acknowledge him. It is posted on the website with an English translation. Thanks to all those who have contributed to the site so far. We are starting to build up quite a range of voices. And for those of you browsing then hopefully we've planted a seed. We'd love to hear from you.

Lament for a teacher

(For Professor Sir John Scott)

Old man, I remember

none of it now,

those secret manoeuvres,

handed down,

how the body should be tipped,

this way and that,

to reveal its secrets.

Only your sad wet

eyes have remained,

but with these I have

seen everything

that is important.

Doctors die knowing
what is to come,
returning from the field
to fetch themselves when
the time draws near.

What is it that pulls?
Here, in the pit.

A thing removed?
Perhaps.
Something growing?

A thing removed?
Perhaps.
Something growing?

Waiatatangi

(Nā tētahi tauira ki tōna kaiako)

E koro, kāore au
i maumahara ērā tohu,
i puta mai i
ngā wāhi ngaro

o te kikokiko.

Mahue noa mai

ō karu pōuri.

Nā rāua i kitea ai

ko te iho,

ko te mauri,

ko te iho,

ko te mauri.

Mōhio nei te tohunga

ko te ngārara

ngōkingōki mai ana.

He aha tērā e ngau ana?

He mea kua ngaro?

E tupu ana?

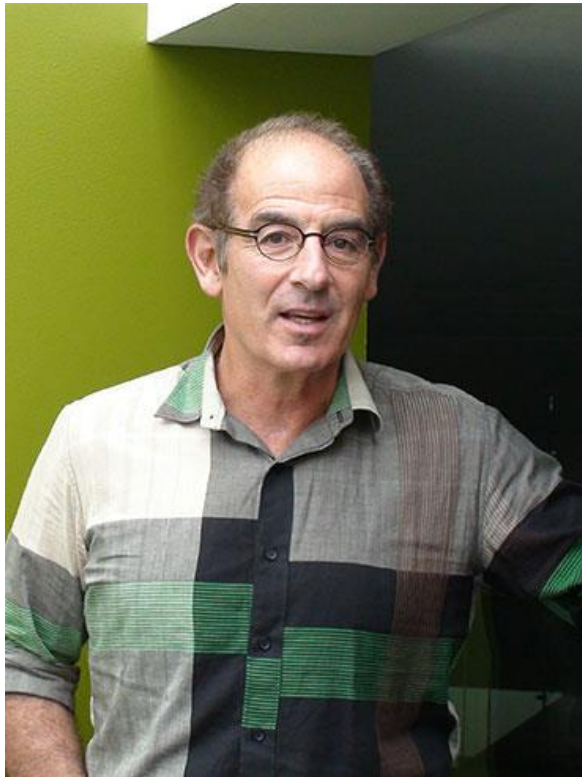
He mea kua ngaro?

E piki ana?

– Glenn Colquhoun

David Galler's Blog: A recent address to the HVDHB

By David Galler -
December 6, 2016



Tena kotou

Ka mihi ki nga tangata katoua

I korero nei

Tena kotou

Tena kotou katoa

I te taha o toku matua

Ko Tatra oku maunga

Ko Vistula toku awa

Ko Lipa Galler

te rangitira

Ko Aron Galler

Toku papa

He tangata ia no hurae

Ko Galler hapu

Ko Galler toku whanau

Ko David Galler toku ingoa

Ko Ema toku hoa rangatira

He kaimahi ahau i te hohipera

nunui rawa atu Tamaki makaura

Ko Middlemore te ra

Hei rata i roto i te ICU

Ka nui tena mo tene wa

Tena koutou

Tena koutou

Tena koutou katoa

Greetings and thank you for the honour to speak with you today.

This is an evening of celebration – Foremost it's an opportunity for the DHB and others to acknowledge and honour you. To thank you for the fine work you have been doing and celebrate your place in the engine of this place, to improve the lives of the people we are here to help.

The QI movement in NZ is still in its adolescence but together we have come a long way in a relatively short time...it doesn't seem that long ago when I sat in international forums elsewhere, listening to the work of others engaged in improvement with my heart racing from embarrassment at what little value we in NZ placed on that kind of an approach.

By way of context, in the late 90s and early 2000s that began to change with the establishment of the Epique Committee sadly without Putea, a ministerial committee with good people but no resources; then we set up the better resourced National Quality Improvement Committee which began a series of national programmes to reduce harm. Following the review of health services led by the former Treasury Secretary Murray Horn in 2010, we set the scene for the establishment of the Health Quality and Safety Commission as a Crown Entity outside of the Ministry of Health.

At the same time, my own organisation, Ko Awatea was formed – we said to accelerate our ability to help our staff and communities help themselves. Across the country too, DHBs began to invest in their own improvement, perhaps led by the pioneering work of the good folk in Canterbury.

Thanks to people like you, healthcare improvement in NZ is becoming a strong bottom up movement and now has a life of its own.

Despite being a Wellington boy, it's still somewhat poignant for me to be here in the Hutt, not so far from Mitchell Park where I played so much tennis when I was younger, and of course very close to Chilton Grove where my mother spent her last few decades of life surrounded by a remarkable group of friends.

My mother Zosia was an impressive woman who, in her tumultuous life, had seen and experienced things no human being ever should. Despite the horrors of a childhood spent in Auschwitz, against all odds she became a wife, mother, grandmother and a loyal friend to many. Fiercely independent, politically savvy, generous and liberal-minded, to those who knew her, she remains a symbol of resilience and strength.

She died not in hospital but at home and during those final weeks, was looked after by a small group of us, my brother Les, my partner Ema, the staff of the Te Omanga Hospice and me.

Because of my longstanding role as an Intensive Care Specialist and perhaps because of some of the other roles I have had over the years, people think I am an expert in matters health and perhaps in some areas I might be, but when it comes to being on the other side, that of experiencing care, I am not. Up to that point in my life before my mother became so ill, I'd had no real personal experience as a patient, and of being at the mercy of well-meaning people like yourselves. For me, it had been an annual visit to my GP and on the receiving end of the occasional scope slipped into one of my orifices – little more.

Over the years though I helped broker care and translate the foreign language of medicine for friends and acquaintances. For those angry with the way they were treated – stories that sometimes upset and embarrassed me – I would always encourage them to complain and on some occasions I would even help them draft those letters. Perhaps like you, my beliefs about what to expect by way of care is entirely based on my perception of how I provide care to others.

So back then when my mother deteriorated so dramatically and we needed help, YOU came through for us and during that time I know my mother was deeply grateful for the care she received and I want to thank you for that. I especially want to acknowledge Atul Dhabuwalla, a surgeon at this place who was gracious and kind in his dealings with my mother when we turned up at his clinic not having done the staging CT scan or had the blood tests he had requested. A little put out at first, I could see the relief come over him when he realised that he didn't need to pretend that doing those tests would change my mother's fate.

That was several years ago now so I've had plenty of time to reflect on what happened then – what we did and what we could have done better – of course, at the time it was a complete whirr, an immersive fog.

I have thought a lot about why things worked so well and about the lessons there to improve care in other areas. What I saw was a set of principles and practice seldom seen, apart from in modern day Palliative Care and Geriatric Medicine. I see these specialities as unique examples of co-design and patient-centred care.

Sadly, in most other branches of medicine we still seem to be more interested in what we do to people than we are in the people themselves. In my mind that position effectively changes us from doctors to technicians.

However, having a genuine interest in people and what matters to them is just the first step – reliably delivering care in a timely manner, safely, efficiently and effectively is another challenge. **That's the one we are becoming expert at eh!**

In my mother's case, the people and the services that helped us, understood and respected her wishes – to stay at home; to be pain free and for her family to be with her.

The hospice staff were kind and worldly – interestingly they were mainly women – but gender aside, what stood out most was how they operated.

What they offered was this: their expertise as palliative care specialists and nurses; a range of equipment both simple and specialised including flash beds and la-z-boy chairs; nebulisers (my mother was a smoker and, as a result of a stroke, had fallen down her stairs and broken her ribs); a walking frame which we used till she could no longer walk – the sight of them still send a chill down my spine; community resources through their links with the local pharmacies and NGOs who could access a wide range of home care options – someone to come in everyday to shower my mother was a godsend; and good working relationships with local GPs and, critically for us as it turned out, with the Wellington Free Ambulance service, to ensure that everyone knew what really mattered to my mother.

This group of people from very different services listened and they cared. They were a good team – there were no obvious hierarchies – and they worked well together towards the same goal. They stayed in touch with us and each other and adjusted what they did on a daily basis to my mother's ever-changing needs.

They were impressive. In fact their care was an example of transformation in action.

Thinking about all of that later I couldn't help but wonder why we spend so much time analysing the bejesus out of the rare things that go wrong instead of systematically learning from the multitude of things that go right?

Well, in fact we are beginning to do that – using simulation, small groups of enlightened people – staff in my own ICU in fact – are recognising the complexity of what we are dealing with on a day-to-day basis and use this technology to invest in people by fostering teamwork and communication skills and in how to create a safe environment to encourage all members to contribute to solving the problem at hand. Some have called this approach Safety 2 – reducing unwarranted variation in our approach to everyday tasks but at the same time fostering easy adaptation to changing circumstances, especially in emergency situations, e.g. a failed intubation or dealing with a cardiac arrest.

This approach, Safety 2, is just one example where we are increasingly recognising that the solutions to the problems we face lie in the heads of our people and the skills we wish them to have. That same thinking applies here in the Hutt as it does more generically to the challenges we face as a nation.

When I refer to our people, I am of course talking about you and me. That is the entire *raison d'être* for tonight; that is why my group established Ko Awatea and I know it's the same for the Health Quality Safety Commission.

I am now in the late afternoon of my career so I feel I've seen most of the issues we are now grappling with several times before! To me they are a manifestation of a repetitive churn of past problems treated with sticking plasters. The recent scandal of people losing their sight because of the unintended consequences of targets is but one example. So too is our perpetual unwillingness to deal with the root causes of the problems that drive so many people to the doors of our health and justice systems.

"The definition of insanity is doing the same thing over and over again and expecting different results." Who said this one? Albert Einstein.

And this: *"Every system is perfectly designed to get the results it gets"* Paul Batalden

And this: *"We have two jobs: to do our jobs and to improve our jobs"*, I dunno who said that but whoever did was pretty smart!

How do we do get beyond this churn – who can do this – well the answer is in the room ... it's us, it's YOU and ME and it's US TOGETHER.

Wouldn't it be great if this government would see the success and wellbeing of all New Zealanders as an investment rather than a cost?

Would it make a difference if we had a Minister **FOR** Health not simply of it.

Maybe we could even create the position of a Minister FOR Wellness, and a vision of health contributing to an even higher purpose for this little country at the end of the world. I am talking about a Vision but also about a Plan, in effect a Driver Diagram for the nation!

The Vision might be something like this:

To ensure that our people, families and communities are well, happy, self reliant and productive; so they can start their own businesses and staff their own businesses; and ensure that all New Zealanders can truly reach their potential.

He aha te mea nui o te ao

What is the most important thing in the world?

He tangata, he tangata, he tangata

People, people, people.

Imagine if we really believed that – and we had a unifying vision, maybe instead of one step forward, two steps sideways and several steps back, we might approach all those things outside health that impact on it in a smarter and more strategic way?

Maybe too a new flag might emerge!

If we all worked **FOR** health and wellness and that unifying vision would we still be facing the same terrible costs from the plague of Obesity and Diabetes that we do now and will in the future?

Would our people have more money in their pocket and not have to sleep in cars and garages?

Might we have already eliminated the scourge of child poverty and Rheumatic Fever from our midst?

It's been a hell of a year – the chaos of the Middle East and the ongoing human tragedy that is Aleppo; David Bowie, Leonard Cohen, Leon Russell all dead; many of us with our own personal battles; TRUMP; and now earthquakes!!!

Where is our place in all of this – what impact might we have on the national and international chaos the world chooses to perpetuate? What does this mean for the work we do? Is there a better way? Well isn't that what we improvers do – constantly be on the look-out and find a better way?

We have plenty of wonderful examples all around us:

The Epuni school near here

The Gardens for Health project in Auckland

The virtuous cycle at the Wiri men's prison where they grow 40% of all their vegetables and all their food waste is recycled in worm farms creating compost for the gardens that feed them.

The Manaiakalani Trust – breaking a cycle of deprivation and failure by propelling students from deprived areas to success in life, through the use of innovative approaches to e-learning at school and at home.

And there are many, many more – All achieving much, but usually quite isolated and swimming against the tide of the status quo– a bit like we were in improvement 15 years ago.

We owe it to ourselves to raise our expectations, to apply the rigor of improvement more broadly because all of us deserve better.

Not just here in the hospital, but out there in our communities.

You are the people who have the skills and the approach to make that happen.

Let's do this.

No reira

Nga mihi nui

Ki a koutou

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Tena koutou

Tena koutou

Tena tatou kaatoa

– **David Galler**

Glenn Colquhoun's Blog: New Fellows' Graduation Ceremony speech

By Glenn Colquhoun -
January 20, 2017



Last year I was asked to speak at the New Fellows graduation ceremony for the Australasian College of Physicians in Auckland. Coming up with something worthwhile to say made me reflect on my own medical education. I realised that the formal part of it ended twenty years ago. That seemed like a small place halfway up the hill to stop and look back from. So I did. I asked myself what I've learnt over time in medicine that has proved to be the most useful to me in the way I practise now. And so with that in mind I scribbled this speech ... and thought I'd post the result here. I reckon it's best left alone to be what it was intended to be as far as a piece of writing goes. I hope it resonates ... or irritates. And don't forget to send us your own thoughts. Most of the doctors I know hate being told what to think. We'd love to hear from you.

"President of the Royal Australasian College of Physicians, Fellows of the College, New Fellows of the College, ladies and gentlemen, I would like to begin by reading you a poem. It is not my own. I wish that I had written it. I need to warn you that it is irreverent. It is a poem I often read to fourth form boys to show them that one of the great advantages of poetry is that you can swear in a poem and get away with it. More than any other social group doctors remind me of fourth form boys and so I suspect you will also enjoy the visceral thrill of obscenity.

This be the verse

They fuck you up, your mum and dad.

They may not mean to, but they do.

They fill you with the faults they had

And add some extra, just for you.

But they were fucked up in their turn

By fools in old-style hats and coats,

Who half the time were soppy-stern

And half at one another's throats.

Man hands on misery to man.

It deepens like a coastal shelf.

Get out as early as you can,

And don't have any kids yourself.

– *Philip Larkin*

Philip Larkin was a distinguished English poet. I have read you one of his best known poems because there are times when I think that medicine is a giant dysfunctional family full of people who are constantly telling you what to do. We have our own equivalents of stuffy old-style hats and coats. We growl our young and expect them to toe the line. We do things sometimes because that is the way they have always been done. We change our minds frequently but never expect to be questioned. I read it too for little other reason than the subversive thrill it always gives me when I open it up and shake it out. God only knows medicine and its Royal Colleges can do with some subversion at times. A copy hangs on the wall of the youth clinic I work at where only too often it reminds me where the pain in young people can begin. It is also a way of saying beware of all standing up here today banging on. I am standing up here and banging on today and so you should especially beware of me. I rarely know what I'm talking about.

I am here above all other things to congratulate you. There are days in life when it is only right to sink like hippopotamuses in the soft ooze of our own warm mud. And so to all of you being admitted as Fellows to the college today I encourage you to wallow. You have earned the right. It is a magnificent achievement. Life throws up these moments from time to time and it is our job to hesitate for a moment in the great rush and enjoy them.

But I cannot simply pack up and leave things at that ... when I was wondering what might be useful for me to talk to you about today I was forced to reflect on my own medical education which formally ended twenty years ago. It was a state of the art education at the time and I do not undervalue it. It downloaded a range of medical information into me that I still bump into now and again when I am trying to figure things out. It was a magnificent assemblage of raw material. But it also occurred to me that in many ways the most useful tools I have acquired in the practice of medicine have been learnt on the job. I will not be able to give you many new insights into medical diagnosis and treatment today but I will open my doctor's bag and take out three tools that have become vital to me in the way that I practice

and survive in medicine now. They are all I have ... curiously enough I learnt none of them at medical school.

The first of these was simply the acquisition of experience. Medicine at the end of the day is a practical profession. No matter how much it is based on what has been written in text-books it was seeing things for the first time myself that brought home to me the shape of a particular illness. I was always a frightened doctor and I suffered for that. Playing God, my first book of poetry, was written under a contract I made with myself that allowed me to leave medicine once it was finished. I didn't of course and I'm not sure when I started to calm down but I did. It took years of paddling to learn how to float. And while part of that floating was brought about by seeing and doing, a significant part was achieved by realising that I would never be able to know everything and that admitting that to myself and to my patients was OK. At least then I could ask somebody else what to do. I think sometimes that we undervalue experience in medicine. It often doesn't feel like anything specific, just a mountain of thrown away scraps. But it is full of buried treasures and I encourage you to value it and to share it. Medical knowledge is a web best held by all of us as doctors. We need to continually ask of each other. And just as importantly we need to make it safe for others to continually ask of us.

In the years after my formal medical education ceased a second tool also slowly evolved in my practice of medicine. Life occurred. I had relationships ... and messed them up. I bought a house. And sold it. I learnt a language. I became a father. I argued with people. I had cars stolen, both of them from hospital car parks. I made mistakes – inside and outside of medicine. I had times of great happiness. I had times of great sadness. I sought therapy. I hurt people. I disappointed people. I disappointed myself. I got sick. I travelled. I learnt things I never thought I would. People came into my life and left it again. People I loved died. I heard myself creak. I watched myself crease. I wrecked my shoulder. I lost faith. I gained faith. I wrote books. My hair fell out. I got up at night to pee. Things did not happen in that particular order of course ... but gradually I began to understand, with a lot more patience, what those people who sat opposite me in consultations were going on about. Over time I allowed myself to simply bring that part of me who came closest to what I thought they were experiencing and let it be there with them. Looking back now it seems medicine comes with so many warnings and alarms that it can simply stop us being at times. And being is such a powerful thing in a consultation. It helps if one person in the room is able to sit in their own skin – and for a long time in my experience that had usually been the patient and not the doctor. When I look at you this morning I see so much life in all of you. You have all had such a range of experiences. There are of course times when our lives need to be kept separate from our patients but there are so many times when our experience of being human can teach us how to be with people. It is a huge resource to make use of.

The third great revolution for me in my medical education, and possibly the one I value most, did not so much rely on the need for time to pass as the first two I have mentioned. Writing, for all that it relies on words, at some point is not really about writing. It is about looking and longing. All art is in a sense. As is all science. And by longing I mean that curiosity we cultivate about what lies beyond, coupled with a desire to be intimate with the universe in some way. Practising a creativity, whether it be in writing, or in music or in visual art or indeed in science or medicine teaches us to look at the world more closely. This is the journey that one goes on over time and which is then reported on in words or with paint or sound or by the asking of exquisite questions. And this journey is in many ways a journey towards looking at the world with a particular kind of compassion.

Art and science make us look at the world with what I call 'wet eyes' – that combination of wonder and care that makes us well-up. This may be a response to the fact that the world is full of layer upon layer of remarkable detail that pulls us ever deeper into it the longer we look at it. But it is also due to the fact that at some point our eyes also reflect a startled wonder at the symmetries, connections, beauty and helplessness that we see. We fall into a sort of love with the world in a sense. When we are looking well our eyes become both portals to look through and mirrors that reflect. I started down the path towards being a writer twenty years ago without having any idea that that what it was really demanding of me was to put down my pen and look at the world more inquisitively and more compassionately.

A few years ago I began to write about medicine again for the first time since composing the poems that became part of *Playing God*. I began to interview some of my patients and record their stories in more detail for a literary project. Of course to do this I needed to use those 'wet eyes' that were part of being a writer. All of a sudden I found that I began to bring that same sensibility into my consultations. Medicine changed for me at that point. Instead of a day fighting my doubt and the waiting room, a day full of consultations became a day spent in a Dickens novel. It was not something to be endured but appreciated. Art taught me to see things with my chest and so I began to look at my patients with my chest. I found that it was possible to see each of them as a poem. It only took a trick of the eyes. Soon I wanted to know more about them. I turned them over in my mind and handed them back to themselves excitedly saying, 'Look, look, I can see something there, and there. It's remarkable.' I'm not sure it made me better at diagnosis or the management of any particular illness, although I suspect it did to be honest. What I did notice is that patients liked the experience of being looked at with 'wet eyes'. I suspect it was that mirror in them that they were responding too. They wanted to see themselves in the way a poet would see them. There's is a medicine in 'wet eyes'. It says we are doomed but doomed beautifully and I am with you. For the last few years that poetry has been an essential part of my consultations. Not that I rhyme my scripts or regale patients with 'The Man from Snowy River' – although less effective therapies have been championed by our profession over the years. But that part of poetry which is about how we look at things has become integral to what I do now.

And this is something that people can learn. The young can learn this sooner in their medical education than we think. In fact often it is the young and the old who are more open to such magic than the middle aged. The way we look at people and listen to them is a medicine. Sometimes people need surgery, or an insulin infusion, or thrombolysis. But sometimes they need 'wet eyes' too – not in the least because 'wet eyes' also help to calm the doctor looking out at the world through them.

I began writing this speech sitting on a post storm beach at Otaki and want to take you back there to complete it. Picture for me the sea unsettled and barking. Salt is beginning to obscure the view of the sun which is setting in front of me. The clouds are tangling into grays and pinks. The fist-like stones that make up the beach are strewn with driftwood and interrupted by patches of spinifex and succulents. The wind gusts over the top of a long and steady moan. Kapiti sits to the south rapidly turning to silhouette. D'Urville curls behind. Taranaki waits to the north, and the Tararua's overlap behind. Foam is blowing up over the curve of the beach. The lights go on all the way down the coast. Everything is hunkering down.

I know this landscape well. Those of you who have spent any time in our country will. And I feel as though it knows me. It attracts and repels and fills us with both melancholy and a desire for warmth at the same time. It builds in us the delight for exposure and shelter and reconciles those opposites into a strange whole. It is not a picture of warm and cold, and love and hate, and past and present, but of warm-cold, love-hate and past-present. Doctors watch a human landscape unfold in a similar way in front of their eyes every day. Human beings also morph in and out of happy-sad, well-unwell and knowing-unknowing. If we look at them with the same wonder that we look at our landscape then we can remain with them in the doubt in between those spaces with a little more ease until their eyes adjust to the same wonders that we see. When the time is right we can so often simply light the fire and sit with them beside its warmth.

I began with a subversive poem and I would like to finish with one as well. One that explains how I came to see some light in all those shadows that consultations can cast at times. It was one I wrote to capture that experience of looking at patients with 'wet eyes' that I have been talking to you about. I wish you well in your careers. My warm congratulations to you all.

Doctor to patient

(on ornithology and the practice of medicine)

You have brought me a bird.

I have seen this before.

When you say,

'I am sore,'

I see a bird.

When you say,

'I cannot breathe,'

I see a bird.

When you say,

'I lie awake,'

I see a bird.

You have brought me a bird.

There is a bird

in the room.

Should I stand on the table?

Should I stand on the chair?

It is singing.

Listen, it is singing.

It is there, in the corner of your eye.

It is there, on your shoulder.

Here, in the pit of your stomach.

Now, between your legs.

Inside your rattle-cage,

when I press

my ear to it,

I hear a bird.

Behind your knee,

in the creep-

dark shade,

hops a bird.

And in your sorrow-joy,

tip-winged and

unbearable,

hangs a bird.

Give me your hand.

Here, it is in your hand.

It is breathing.

Listen, it is breathing.

Should I dance?

I should dance my old man's dance.

You have brought me a bird.

How can this be?

You have brought me a bird.

Holocaust Memorial Speech

By David Galler -
February 8, 2017



Holocaust Memorial Speech

(He Korero Maumaharatanga mo te mate Kohuru Kino nui i te wa o te Holocaust)

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Korero whakataki**Tihei mauri ora!**

E nga mana, e nga reo, e nga iwi o ngaa hau e wha, puta noa te ao, tēnā koutou.

Ngaati Whaatua, me nga rangatira o tēnei hui, kia ora koutou.

Tuatahi,

Ka mihi ki te atua me ngaa mate puta noa, moe mai raatau ki roto i ngaa ringa o te atua.

Tuarua,

ko taatau tenei te hunga ora kua tae mai ki runga i te karanga o te kaupapa, ara,

Te “Ra whakanui mo te Runanga Whaka-kotahi i nga lwi o Te Ao, hei mau-mahara-tanga ki nga taangata i whaka-kohuru nui-tia, i te wa o te Holocaust”. He hui-a- tau, 27 January.

Tuatoru,

Anei taku Pepeha.

I te taha o ooku maatua.

Ko Tatra te maunga

Ko Vistula te awa

Ko Lipa Galler

Te tupuna.

Ko toku matua

Ko Aron Galler

He tangata no te whenua o Hurae

Ko toku whaea

Ko Zosia Galler

No Poorana.

Ko Ema toku hoa rangatira

Ko David Galler toku ingoa

Speech introduction**Hear ye!**

Distinguished ladies and gentleman from the four winds of the world, greetings to you all.

Ngaati Whatua, and to the organisers of this gathering, greetings.

Firstly,

Praise the Lord and in memory to our loved ones who have passed on into his loving arms.

Secondly,

We the living are gathered here in Remembrance to the call;

By the United Nations for; “The International Day of Commemoration of the Victims of the Holocaust,

which is observed each year on 27 January.

Thirdly,

Here is my motto/proverb.

Referring to my parents.

Tatra is the mountain

Vistula the river

Lipa Galler

Is my ancestor.

My father is

Aron Galler

Who hails from the land of Israel

My mother’s name is

Zosia Galler from

Poland.

My wife’s name is Ema

My name is David Galler

He kai mahi ahau i te Hohipera nunui rawaatu,
puta noa te Ao

*I work at the biggest hospital in the world –
Middlemore (Comic statement)*

Ko Tamaki ki raro teera, ara ko Middlemore
Hospital.

Ko au tetahi o ngaa Rata ara, Taakuta Poka i roto i
te ICU.

I am one of the doctors, a surgeon in ICU

Kaati,

Therefore;

Ka hoki wairua taku whakaaro, ki ooku maatua, ki
ooku tupuna mo eenei korero arohanui, i homai e
ratau ki ahau. Waimarie katoa au.

Spiritually I think back in memory to my parents
and to my ancestors for their stories handed
down to me. I am so grateful.

Ka huri ki te reo Pakeha.

I will speak in English.

Holocaust survivors and your families; Members of Parliament; Hon Dame Silvia Cartwright;
Hon Consuls; Mayor of Auckland, Phil Goff; Heather Harris, Acting Director/Chief Operating
Officer of the Auckland War Memorial Museum; distinguished guests.

On this day, deep into the northern winter of 1945, Russian forces liberated the
concentration camps of Auschwitz and Birkenau.

For several weeks prior, the extermination of prisoners had been accelerating. Ten days
before liberation, the SS forced 60,000 surviving prisoners out of the camp on a brutal march
into Upper Silesia. From there, on foot and in freight trains, they made their way into
Germany. My mother Zosia Galler, the sole child of Hilary and Cecilia, an orphan at just 15,
was one of them.

My mother's number was 72154. I grew up seeing the tattoo on her forearm. The seven was
written in the European style, with a stroke across it, which is how I write it now. She
acquired it immediately on her arrival at Auschwitz by train, having been crammed into a
freight car with her mother and so many others that many died of asphyxiation before they
could be more formally killed later. Hilary, her father, had been shot in front of them at
Gestapo headquarters in Katowice a few weeks before.

This is my mother's memory as she recorded it for us in her memoir, *As It Was*:

*My mother was holding onto me and when we came out we were standing on a platform in a
crowd. On the opposite side from us, in a row, was standing the Gestapo, the SS men, and
around were soldiers with dogs. The soldiers were armed to the teeth with helmets and guns
and here was this little huddle of people, old men (because the young men were all gone),
women, children, old women, fainting with hunger, filthy and holding on to their few
possessions. And out from the row of SS men came this tall man in a black uniform, with
shiny leather boots, white gloves and a beautiful black rod in his hand. He was the most
handsome man I had ever seen in my life, as long as you didn't look into his eyes. His eyes
were unbelievable ... this was Mengele. He started going through the crowd – he formed us
into rows with five people in a row. And he started going through the rows with the guards
on both sides and he was tapping people on the shoulder saying: "Liech", "Reicht", "Liech",
"Reicht" – "Left", "Right", "Left", "Right". Then he came to us and he looked at my mother.
"Reicht". I clung to my mother and I was lucky. I was very well-developed for my age and was*

already a bit busty and he looked at me and tapped me on the shoulder "Reicht". My mother put her arm around me and we ran to the right and my mother looked at me. "Oh, Zosia," she said to me, "I think we are lucky. We are between the younger ones."

But then she looked up and I did too as, all of a sudden, a grey pall came over the sky – a yellowy grey pall coming out of huge chimneys. And then all of the stories we had heard seemed to come true. And my mother looked at it – and then I will never forget what she said to me – "Remember, you have to be strong because I will never come out of here." We had arrived at Auschwitz-Birkenau.

She was right; my grandmother, the beautiful Cecilia, died the following winter in Auschwitz at the hands of Joseph Mengele.

Unlike the many millions of Jews, Gypsies, communists, homosexuals and so-called 'undesirables' who were exterminated during that time, my mother survived. She said it was **by luck**. But how could life go on for her after what she saw heard and withstood?

She was forever haunted by those experiences but thanks to the enduring and patient love of my father Aron, Zosia Galler became a generous, loving, glamorous, liberal minded woman and a friend to many.

It is therefore a great honour for me to stand here today to speak on her behalf and that of her parents and their community. I also speak on behalf of my father, who escaped Poland in 1939 to join the Polish Army abroad; and for his parents, younger brother and sister, and her young daughter, all of whom were killed by the Nazis. And finally, I speak on behalf of my family, my brother Leslie on call in the ICU just over there at Auckland Hospital; my partner Ema, sitting in the Alcohol and Other Drug Court further down the hill; and finally our two children, Max and Petra, who are both here today.

I have thought about what my parents would want me to say this morning. My sense is that their very first thought would be to express their gratitude for the wonderful life they shared here in far off NZ but also to implore our government to immediately increase the quota of refugees we accept.

And secondly, I know they would urge all of us, individually and collectively, to seek practical ways to honour those who were lost and have suffered; and to turn the memory of that collective horror into positive action for good, because by now it must be obvious to all of us, that building Holocaust memorials and just simply remembering has not been enough to protect those who are still in peril.

To his dying day my father could not believe **his luck** to have ended up in NZ, Wellington to be exact. He seized the chance to start a new life so far away from the horrors of Europe and later, he felt luckier still to have met my mother in Israel in 1952.

For my mother **luck** was always a double-edged sword – she said she survived by **luck** because there was no other way to explain it. But with that came a lifetime of anxiety, nightmares, and the ever present question of, 'Why me and not them?', and as a result of that, the guilt that survivors so commonly feel.

Despite their devotion to one another, life in 1952 NZ was not easy for my mother– she had experienced things no human should ever experience. She knew no English, and spoke with

a thick Polish accent. Everywhere she went people would stare at her and the tattoo on her arm. She ate different food, she dressed differently and for quite some time she missed the life she'd left in Tel Aviv – the place she had made her home since 1947.

Ironically, it was these very differences that attracted people to her; like her mother, she too was beautiful; in company she was gracious and funny and people flocked to her. Wherever she went she soon became the centre of attention but always, behind all of this, was an ever-present anxiety born of her past and a sense of worry about what might happen.

Having been told so often by the doctors that my mother would never have children, years later during his speech at my brother's bar mitzvah, my father, not a medical person, once again, attributed our presence to **luck!**

Les and I used to joke that maybe this was one of the reasons why my mother had so little to do with doctors. Later in life she would repeatedly say, "What do they know, why would I ever want to go and see them, they will just tell me I've got cancer". This was another manifestation of her anxiety; my mother was to the last a fatalist and believed that what she didn't know wouldn't hurt her. In the end she was proved right about all those doctors, when eventually her own luck ran out. On her first visit to one in decades she was told just that – "You've got cancer".

Looking back, fate, luck, call it what you will, the bizarre turns in my parents' lives, delivered them generous helpings of both horror and happiness.

I have been **luckier** still. As a result of my parents' sacrifices and thanks to the beneficence that was part and parcel of growing up in a different NZ, the one we were so proud of when I was a child and student, I have been spared the hardships suffered by my parents' generation and that of many today. I have been free from poverty, homelessness and even student debt, and certainly endured none of the misery that continues to afflict survivors and refugees of countless conflicts around the world.

But my parents taught me that with good fortune comes responsibility – in practice that seems to have been translated into an ongoing desire to engage with people; in recognising the many more things that bind us together as people than divide us, and how our trajectory as people and a nation is so intimately tied to the fate of the environment around us.

In the last decade of her life, my mother and I spent a lot of time together – usually over dinner at her place – eating her fabulous spinach and chicken crepes or occasionally the less fabulous chicken goo or on occasions, working our way through a mountain of Chinese takeaways. In truth it was me who did most of the eating – mum never ate much, preferring a glass of wine and a cigarette to food, but she was a great conversationalist and around her kitchen table, we talked about all sorts of things.

One evening she recounted a discussion with her closest friends – a wonderful group of women, almost all widows like her. All of them got their news from the same place – from the radio, the television and the *Dominion* newspaper. As a result they were steadily becoming increasingly fearful and anxious, obsessing about all the bad things reportedly happening in their own community and the wider world and with that they were overcome with a debilitating sense of hopelessness and gloom. "NZ and the world were going to hell in a hand-basket" was how they described things.

Our conversation, though, took a different direction – a more positive one. We spoke about the 1000 acts of kindness and love that everyday bound those terrific women together and them to their other networks of family and friends: the morning phone calls to check up and see that each other was OK; the visits; the dinners; the constant “What can I do for you?”; the genuine interest they had in each other’s lives; the endless and lively chatter. We thought, if only we could bottle that positive energy so we could send it where it was needed, when it was needed.

Of course, we also talked about those dark times in the 30s and 40s, how ordinary people could so easily have abandoned their humanity and stood by while such atrocities were committed.

We talked a lot about the world today – and wondered whether there will even be a tomorrow for much longer, and if there is – what it will be like for our children and their children. We confronted that terrible feeling of helplessness in the face great challenges: poverty and desperation at home; global warming and the impact of climate change; the turmoil and conflict elsewhere; the horrors of places like Aleppo, and so many other instances of cruelty and hate that seem to be on the rise – all things that scare us and turn us inwards, away from other people.

Looking around today we are surrounded by it more and more thanks to the likes of Putin, Trump and the European far right of Le Pen, Wilders and others who ban selected media outlets and accuse the mainstream media of telling lies; just between you and me, my mother would add Benyamin Netanyahu to that list. There are so many pressure points that could easily lead to an even greater conflict that will consume more and more of us, and our planet.

So, how should decent people act? What should we do?

When we talked about those things at the kitchen table we always came back to the same answers – the need for each and every one of us, individually and collectively, to reaffirm in the most practical ways our commitment to truth, to dissent and to each other:

1. **To truth**, because the ideal subject of the slide down to totalitarian rule is not the convinced Nazi or dedicated communist, it is the ordinary person for whom the distinction between true and false, fact and fiction no longer exists. As President Obama said recently: “This practice of selectively sorting our facts is ultimately self-defeating and more perilous to our democracy than any bomb.”
2. **To dissent**, because as annoying as it can be to those who pull the purse strings or hold the power, dissent can be the highest form of loyalty and indeed, for a nation, the engine room of a healthy democracy.
3. **To each other, ultimately**. As put so well by the protestant pastor Martin Neilmoller, himself a holocaust survivor:

First they came for the socialists, and I did not speak out because I was not a socialist.

Then they came for the trade unionists, and I did not speak out because I was not a trade unionist.

Then they came for the Jews, and I did not speak out because I was not a Jew.

Then they came for me, and there was no one left to speak for me.

Sadly the lessons from those dark times seem to be continually lost on many, confirming that the one thing we learn from history is that we may never learn. The dangers of indifference, the fragility of our democracy and an ongoing absence of moral and ethical leadership are still prevalent today and together, they permit the suffering of millions to continue, stopping them reaching their potential as citizens of our world.

Today of all days should be a time for self-reflection, to question 'the inevitability' of what history delivers and to examine our role in making our world a better place.

– speech presented by David Galler at the UN Holocaust Commemoration Service, Auckland War Memorial Museum, 27 January 2017.

Contributors

Nadia Ali

I am a sixth year medical student at the University of Auckland and (all going well) will be graduating in November 2016.

Angela Andrews

PhD candidate in Creative Writing, International Institute in Modern Letters, Victoria University. I have previously worked as a doctor.

Jeff Brown

Jeff Brown is a Paediatrician at Palmerston North Hospital and in the community of MidCentral DHB. He is one of those who started The Medicine Stories Project and has summoned up the courage to submit some work of his own.

Glenn Colquhoun

Glenn is a GP working in a Youth Health Service in Horowhenua.

Dr Sinéad Donnelly MD, FRCPI, FRACP, FACHPM

Sinéad Donnelly is from Ireland. She has worked as a doctor in Ireland, USA and Scotland. For the past seven years, she has been working in Aotearoa New Zealand. She is a specialist in palliative medicine and internal medicine working in Wellington. As an extension of qualitative research Sinéad has produced six documentaries in Irish and English, exploring how children grieve, ancient Irish traditions of dying, how families care for relatives dying at home in Ireland and New Zealand and, most recently, a documentary on a unique rural parish in New Zealand. Sinéad writes as a way of making sense of her world.

Jessica Ford

I am a 4th year medical student currently working in Tauranga. As this is my first year on placement, I have an interest in everything and am enjoying the fast- paced environment of the hospital! At the moment I am very drawn to women's health, but am keeping an open

mind as I make the transition into clinical medicine. I grew up in the beautiful Hawkes Bay, and my love of both biology and working with people from various backgrounds led to my journey into the medical world!

David Galler

Dr David Galler is the son of Polish Jewish refugees. He is the author of 'Things That Matter: Stories of Life and Death', a memoir of his work as a Middlemore Hospital intensive care specialist.

Greg Judkins

I have been a GP and GP teacher in a high-needs multicultural suburb of South Auckland for a very long time. A love of the people I encounter and a love of words, coupled with a desire to do something creative in the autumn of my medical career, has led me to experiment with poetry and short fiction writing. It's proving to be more fun than I ever imagined, as well as emerging as a tool to sharpen my own sense of empathy and curiosity into the stories embedded in the lives of my patients. I have also discovered that creative play with words can be learned from one's children and grandchildren.

Trevor Lloyd

Trevor was born in rural Southland. He has been a GP and rural hospital doctor in Vanuatu, Central Otago and Northland, and now works at Dunstan Hospital in Clyde. He and his wife, Joan, have three children and live on a small farm near Bannockburn.

Alistair Macdonald

I've worked in UK, USA, Canada, Vietnam, Iraq, East Timor and New Zealand. I've been a long time renal physician but I've also collected fruit flies. I've been a GP and a director of family planning. I'm now a clinical ethics advisor and I honestly think it's about time I settled down to a stable career as a clinical ethics advisor ... I think!

Jill McIlraith

Born in South Africa with an original career as a newspaper journalist during the tumultuous 1970's in Johannesburg and Cape Town, Jill has now lived in Dunedin for nearly 30 years. She works as a general practitioner at Aurora Health Centre in South Dunedin and sexual health doctor at the Southern DHB. When not at work, she still dabbles in writing and enjoys her animals, including four dogs, gardening, reading and watching science fiction movies with her neurologist husband.

Jane Millar

Jane is a Kiwi paediatric registrar who moved to South Africa in 2015. She is now coordinating a clinical study and a Clarendon Scholar for her Oxford University DPhil in Paediatrics – in-utero HIV infection, the potential for cure.

Art Nahill

Art is a general physician at Auckland Hospital who emigrated to NZ from the U.S. ten years ago with his kiwi wife and two boys and now enjoys rugby, cricket, and watching American politics from afar.

Lucy O'Hagan

*General Practitioner and Medical Educator
Wanaka
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Nicola Pereira

Nicola is a Paediatrician with special interests in Diabetes and Endocrinology, and Palliative Care. Originally from Zimbabwe, she has worked at Midcentral Health for the last thirteen years. She lives with her husband and their two daughters in the Manawatu.

Paul Reeve

Paul Reeve is a general physician in Waikato Hospital. He was brought up in Hong Kong, went to medical school in London and worked in Africa and Vanuatu before moving to New Zealand.

Bridget Taumoepeau M.B. Ch.B., FRANZCP, B. Theol.

"I was born, brought up and graduated in Medicine in Scotland. I then lived and worked in Tonga for over 10 years, where I was an employee of the Tongan Health Ministry, working in various roles including the training of local health workers. My children were born and raised in Tonga in the extended family system, before we all came to New Zealand, where I completed my Psychiatry Fellowship. My practice has been mainly in Maori Mental Health and the rehabilitation of those with serious mental illness. In my retirement I fulfilled a long held wish to study theology by attaining a B Theol from Otago University. I continue to try

and promote the interface between spiritual and mental well being and am involved in chaplaincy in mental health services as well as agencies working for young people and their families.”

Anja Werno, MD PhD FRCPA

Anja is the Medical Director in Microbiology at Canterbury Health Laboratories, Christchurch and ASMS branch president for Canterbury. “On the Other Side” is Anja’s second contribution to The Medicine Stories Project.

Jin Xu

I came to NZ from China at the age of 10. I am currently in my final year of medical school. Outside of work, I love to read and write. Though English is not my first language, I think the wonderful power of creativity is inherent to anyone, and transferable between any languages. The hospital, to me, beyond the scope of a clinical work, is also an amazingly fertile place for the seeds of creative and reflective writing to grow and flourish.

*This publication is a compilation of contributions to The Medicine Stories project between 2015-2017 curated by Peter Murgatroyd, Library and Knowledge Services Manager, Counties Manukau Health. (<http://themedicinstoriesproject.co.nz/> ; <https://web.archive.org/web/20200114044348/http://themedicinstoriesproject.co.nz/>)