TWJ Foundation Fellowship to Auckland

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Hiking in Piha with my family

I would like to thank the TWJ Foundation for the incredible support and opportunity I was given through receiving a major TWJ Fellowship.

After speaking to previous fellows I set my heart on the Auckland fellowship. I submitted my application in January and interviews were in person in March with some of the panel attending via video link and held in the newly renovated Royal College of Surgeons. At 3 weeks post-partum I had arranged help with my newborn son at home to allow me to attend and I was sufficiently excited that the sleep deprivation wasn't an issue for the next few hours. The panel members were very friendly and asked fair questions about my prior experience and ambitions and a short while later I received a call that I had been successful in my first choice of placement.

Getting there

I was keen to kick things off straight away but the New Zealand Medical Council won't let you apply until 6 months prior to your start date. Despite starting the process as soon as possible, I was still waiting for confirmation of my visa 6-8 weeks before the fellowship start date (partly due to some back and forth with HR over the start date). Fortunately my husband was also going to work (as a GP) and so I applied for a "partner visa" and our 2 kids were also allowed to enter New Zealand on his visa. An unintended benefit of this was free healthcare as his visa was valid for 5 years (not the case if coming in on a 1 year visa). I would strongly recommend requesting a longer visa (at least 2 years) to ensure healthcare is covered (emergency care is covered for all, but nothing more).

I had found a house for us to stay in via Facebook - the “Fellowship Life Transplant” page. This was located in the suburb of Epsom which was well placed for the 5 hospitals that I travelled between (Auckland City, Starship, Gillies, Greenlane and Ascot). We rented out our house in London through the same Facebook page (no agencies involved, some trust required). We invited our nanny to come to NZ with us for the year, to look after our 2 kids aged 1 and 3 which undoubtedly made the whole transition easier for everyone.

Views over Auckland harbour when we first arrived

The hospital provided relocation expenses and accommodation for our first week before our year-long rental started. We also had use of a hire car for that time before picking up the cars that we had bought off the previous fellow. We arrived on “Matariki”, a national bank holiday to celebrate Māori New Year. It was a gorgeous, sunny winters day and we were pleasantly surprised by the mild climate and 20-degree temperature.

After a weekend of settling in I started at Auckland City Hospital. We had a cultural induction lead by Māori cultural liaisons and discussed how to create justice in healthcare when there is inequity within the system. I shadowed the previous fellow Paul Lock, from Singapore for 10 days in the role before I took over the reins.

Timetable

Monday
Ward round at ACH
AM – Private cochlear implant list at Gillies
PM – Public clinic
Once / month – private skull base list at Ascot

Tuesday
Ward round at ACH
All day – Auckland City Hospital – skull base list / joint with Neurosurgeons 2x month
Once/ month – All day Paeds list at Starship Hospital
Once / month – Morning Clinic / PM – Admin

Wednesday
Ward round/Grand Round/ Theatre planning meeting
AM/PM – Clinic or Theatre
Once/Month – all day Admin

Thursday
Ward Round
AM – Theatre – Greenlane or Starship
PM – Clinic

Friday
Ward Round
All day – Theatre
Once/month – PM Private CI list

The wider team consists of a general ENT and head & neck team who conduct separate ward rounds and the bosses operate a separate on call service. Within the general ENT team there are 2 house officers and 2 registrars (a junior and senior). There is a reliever system of house officers and registrars to cover the ward or clinics in case of sickness and effective managers work well within the team. The role included scheduling theatre lists, taking otology and skull base referrals from other regions and managing inpatients and emergency operating.

Funding

1. TWJ funding (27,500 GB pounds tax-free)
2. 2nd 6 months – I was paid by the hospital 89,500 NZ dollars for 6 months (approx. 39,000 GB pounds, taxed at 30%)
3. There were opportunities to pick up locum Saturday clinics and occasional theatre sessions which were well paid (4,000 NZ dollars for a full day clinic)
4. There was also a generous study budget – 16,000 NZ dollars for the year which could be used on any course, conference, text book or IT/phone/computer/loupes etc.
5. There are opportunities for smaller grants from the RCS and from implant companies which can be used to cover flights etc.

Courses and conferences

1. NOTSA (Balance) meeting in Sydney. Met with Michael Halmagyi and Ian Curthoys who first described the Head Impulse test.
2. Otology / Neuro-otology Fellows' course in Little Rock, Arkansas run and supported (the course, food and accommodation was all free) by John Dornhofer.

3. The Adelaide Advanced FESS course – run by PJ Wormald.

Teaching

1. I taught on the Auckland Temporal bone course and the hospital had a temporal bone lab available for use at any time.
2. Grand rounds took place on a Wednesday once a month, delivered by the ENT subspecialties in turn.
3. I gave teaching sessions to the registrars every 2-3 months on various otology and skull base topics.

MDTs

1. Cochlear implant MDT was held once a month on Zoom for adults and paeds (separate).
2. Adult radiology meeting – every 3 months, organised by fellow.
3. Morbidity and mortality meeting – every 3 months, organised by fellow.
4. Paediatric radiology meeting – once a month.
5. Skull Base MDT/NF2 MDT – once a month.

Outpatient clinics

I was timetabled for adult clinics at Greenlane Hospital. The majority of consultations were face-to-face and most patients had had audiograms done privately prior to referral. Clinic and operation notes are dictated and transcribed. Thursday afternoon was a joint clinic with all the otologists present and a great learning opportunity to discuss complex and challenging cases. Hearing aids are not publicly provided until patients have a moderate to severe bilateral loss, although there are exceptions for children and those in fulltime education or with other disabilities or caring roles. There are limited audiology services available through the public system with a long waiting list and patients were encouraged to pay privately for tinnitus therapy and vestibular physiotherapy where possible.

Inpatients

Ward 74 is the main ENT ward in Auckland with highly skilled nursing staff. There are two other major ENT hospitals across Auckland (North Shore and Middlemore) but ACH is the main admitting site for ENT across all of these and the registrars across the Auckland region are all on the on-call rota at ACH. The building and facilities appear well-worn but this doesn't affect the quality of the clinicians or care provided (the NZ public healthcare system is in crisis much like the NHS). Signage and notices are written in Māori and English and the use of Māori words is encouraged. Notes are done on paper. The treatment room was well stocked and organised and the registrars were skilled in handling the majority of emergencies in A&E and avoiding admission (endoscope and bipolar diathermy for dealing with epistaxis and post-tonsillectomy bleeds). There is no on-call requirement (no weekends or overnight work) but the expectation is that you would be available to take any otology or skull base case to theatre. The timetable varied each week.

Logbook and operative experience

The registrars rotate every 6 months and are present in public clinics and theatres. There are no registrars present at the private lists (both cochlear implant and skull base). As the cochlear implants are publicly funded the fellow is the main surgeon for these operations. For private patients it is at the boss' discretion how involved you will be in the case (usually a more minor or assistant role). The consultants are happy for you to be the main surgeon and good at holding back if you encounter difficulties. There are also regular adult lists which are "fellow lists" and there is no direct supervision (but consultants are available on the phone or can be found if needed). As I managed the theatre scheduling I was able to ensure appropriate cases were scheduled onto my fellow list, or to arrange for more complex skull base cases to fall on a list where I was supervised in theatre. Michel is the clinical director for Starship (paediatric hospital, on same site as ACH) as well as busy in the private sector so there were frequently additional ad hoc opportunities for more theatre exposure.

Obesity and chronic ear disease is common amongst the Māori and Pacific Island population in addition to an epidemic of poorly controlled diabetes. Patients frequently don't attend their GP for chronic condition management or repeat prescriptions as there is a charge for primary care. Necrotising otitis externa (NOE) was common and the infectious disease teams pushed for "deep tissue biopsy" in the form of a cortical mastoidectomy to try to isolate the pathogen. Nuclear medicine scans were used to diagnose and follow up these patients. Several patients recurred and they were challenging to manage. Many of the patients requiring mastoidectomies would weigh 100-150kg with limited neck rotation, so body strapping to allow table rotation was routine. In one 203kg patient requiring cochlear implantation we modified the placement of the receiver stimulator package to sit over the temporalis muscle in order to facilitate magnet retention due to a 15mm skin flap thickness.

The operating case mix was varied and included adult and paediatric implants (632 or 612 electrodes) and OSIA. Cochlear (being an Australian company) has the majority of the auditory implant market in New Zealand. There are many rural communities in New Zealand and the distance for travel to rehab appointments is an issue, so the service is working on more remote mapping options for patients. Several of the implant cases we performed were post-meningitic patients requiring full cochlear drillouts. Another child with CHARGE syndrome and abnormal facial nerve anatomy had a completely obliterated round window. Stapedotomies were done using a reverse technique, a hand-crimp piston and without the use of laser.

Chronic eustachian tube dysfunction and excessive allergic disease resulted in many under-pneumatised small, sclerotic, mastoids which tended to re-retract. I became familiar with canal wall down techniques including modified radical mastoidectomy. I learned how to manage healing cavities and epithelialising ear canals following canalplasty/exostosectomy. Idiopathic intracranial hypertension was very common and I performed several middle fossa repairs for CSF leaks and meningo-encephaloceles with excellent results. Extensive CSOM and cholesteatoma presented frequently with lateral canal fistulae, acute mastoiditis or occasional intra-cranial complications. Several patients would come over from the Pacific Islands for treatment (e.g. NOE or vestibular schwannomas) and pragmatic decisions were required about their ongoing care afterwards when they were repatriated to a resource-limited setting. Ear canal cholesteatoma was a frequent finding and one patient presented with a Bezold

abscess from this. I performed a lateral temporal bone resection for a giant facial nerve schwannoma as well as for malignant disease. Vestibular schwannoma management was predominantly surgery-focused. NF2 patients were discussed in monthly MDT meetings.

Total operations: 334

CAT/ atticotomy/modified radical mastoidectomy – 67
Emergency cortical mastoid – 13
Cochlear implant – 30
    - Post meningitis – 6
Canalplasty – 22
Stapedotomy – 9
Translabyrinthine approach to excise vestibular schwannoma – 19
Translabyrinthine approach to petrous apex – 1
Retrosigmoid approach to excise VS – 1
Tympanoplasty – 46
Lateral temporal bone resection – 2
Pinnaplasty – 2
SSCD resurfacing / plugging
    - Middle cranial fossa approach – 3
    - Transmastoid approach for SSCD – 2
CSF leak repair – 8
    - Transmastoid – 4
    - Middle fossa – 4
OSIA – 8
Blind sac closure – 8
Subtotal petrosectomy – 5

Summary

Both personally and professionally this has no doubt been the best year of my life to date. The bosses I have worked with have been truly inspirational and will remain lifelong friends. It has been wonderful to share this experience with my husband and 2 kids who thrived in this beautiful, peaceful, welcoming country. Children and childcare are prioritised and we found a wonderful nursery “kindy” for my daughter which blew the socks off anything I had seen in the UK. The parks & playgrounds are extensive, clean and encourage adventure, and the subtropical climate meant that we were able to go to the beaches in the city all year round. Ponsonby road had an exciting food scene and the proximity to Waiheke Island was brilliant for weekend wine tours (and orca spotting). We loved the friends we made there, and spent weekends travelling to Russell, Nelson, Mt Manganui and Piha and tried out skiing in Mt Whakapapa. Proximity to the Pacific Islands was an added bonus and we holidayed in Fiji and experienced tropical paradise more than once.

Saying goodbye to the most fantastic bosses (Michel and Tanja) and welcoming the new fellow Youssef


The theatre team at ACH

Sunny rooftop lunchtimes with the ENT team at Starship (Selena, Bena, Jen, Dora and me)