Middle Articles

New Medical School for New Zealand

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New Zealand's first and only medical school was established by the then University of Otago in Dunedin in 1874. Subsequently the universities of New Zealand were amalgamated as university colleges under a central examining body, the University of New Zealand, and the degree from Otago was granted by the University of New Zealand. Five years ago the university colleges were granted their autonomy, and the University of Otago now has full control of the M.B., Ch.B. degree. However, two of the six years of the course have always been taken elsewhere by a number of the students. Most of the students from the North Island and the northern parts of the South Island have taken their first science year at one of the three main universities and their final year at the corresponding hospitals in Auckland, Wellington, or Christchurch, returning to Dunedin for their final examinations.

Though this situation has proved very satisfactory, over the years it has become increasingly obvious that a second school will need to be established. More doctors are required, both within the country and for outside the country, particularly the South Pacific area. In addition, there has been some dissatisfaction about the method of entry into the second year of the medical course in Dunedin as a result of an examination held in different parts of the country. A somewhat complicated system has been evolved, and this is felt by some to be less than adequate.

Planning of the School

For the past ten years or more there has been talk of a medical school in Auckland, the present Chancellor of the University of Auckland, Sir Douglas Robb, Past-President of the British Medical Association, being one of the chief architects of this idea. Practically no dissension has arisen from the other centres in New Zealand about the siting of the new medical school; all have agreed that Auckland is the logical place.

At the beginning of 1964 an advisory committee of local doctors and university professors was set up to advise the Senate of the University of Auckland on the academic implications of the medical school. The chairman was Professor D. G. Bonham, postgraduate professor in obstetrics and gynaecology at the University of Auckland. In December 1964 the committee produced its first report, which was forwarded to the Grants Committee. Since then the Grants Committee and the Government have declared that the Auckland school may now be formally planned, and the aim is to establish medical training, starting with a preclinical year in 1968. Professor C. W. D. Lewis has been appointed dean.¹

Location

The timing of the various parts of the medical course is very dependent on the rebuilding of the Auckland University,

which is now taking place. The present plan calls for a limited intake of 50 students intending to undertake medicine, who will enter the preclinical three-year period in 1968. It is hoped this will be increased to 100 premedical students by 1970-1, depending on the facilities of the main university. In addition the preclinical period, as indicated below, will then cope with a number of non-medical students.

The clinical studies will start in 1971, and the medical school itself will need to be built opposite the main Auckland Hospital about 1 mile (1.6 km.) from the university itself. One of the major problems in Auckland is the fact that the hospitals under the control of the Board are somewhat scattered and the specialties are divided up between these hospitals. Three of the major hospitals are within 5 miles (8 km.) of each other, but the largest of all at the present time (though to be superseded by the new main Auckland Hospital) is Middlemore Hospital, which is 10 miles (16 km.) from the centre of town.

Preclinical Curriculum

The advisory committee has embraced most aspects of the working party report² from London. With the active and enthusiastic encouragement of the science professors at the university the conception of the three-year Bachelor of Science (Human Biology) course has been chosen. The planning of this part of the medical course is conceived on a basis of a maximum of 100 medical students and 100 other students for each year of the human biology course. It is assumed that this B.Sc. (H.Biol.) will provide graduates for many other fields allied to medicine as well as the teaching profession and many aspects of biological research. One of the difficulties that the Grants Committee has recently considered is the problem of integration of this type of preclinical course with the existing and more conventional course offered by the Otago University.

Not unexpectedly one of the major problems in the preclinical course has been the place of anatomy. The recommendation of the advisory committee reads: "There should be considerable reduction in the number of hours spent during the preclinical period on anatomy. Dissection of the whole body should be retained but done during 160 hours in a second year. The third year should include neuro-anatomy and more advanced aspects of embryology and histology. This third-year anatomy would be optional for students who are not proceeding to the clinical phase. Further anatomy should be included during the clinical course in association with topic teaching. Detailed topographical anatomy should be retained only for specialists during their training for advanced postgraduate diplomas."

It suggests that the time saved on teaching anatomy would be valuable in broadening the physiological and biochemical aspects of human biology and greatly enlarging the subjects

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¹ *British Medical Journal*, 1965, 2, 543.

² Malleon, N., School of Medicine and Human Biology. Report of the Working Parties, 1963.

which have been broadly grouped together under the heading of behavioural sciences. The advisory committee states: "Biochemistry should play a major part in medical education both in preclinical and clinical years. Biochemistry should be taught in a large general biochemistry department within the University of Auckland. The development of biochemistry as a science subject in its own right is essential to the University of Auckland."

Clinical Curriculum

The clinical curriculum is only now being considered by the advisory committee, and the timely publication of the interim report of the fourth working party of the School of Medicine and Human Biology³ has been added stimulus to this discussion. The clinical group has decided to introduce the concept of topic teaching, though, in contrast to the recommendation of the working party report, it will probably endeavour to teach this throughout the fourth and fifth years. The clinical teaching will be done in groups of 10 to 15 students, each with a tutor and a representative group of surgeons, physicians, pathologists, general practitioners, and others. The sixth year, it is hoped, will be a residential appointment as an at least partly paid residential assistant. Such assistants will rotate through many of the hospital departments as well as some of the field appointments covering general practice, obstetrics in outlying hospitals, and social medicine in general. Graduation at the end of the sixth year will lead to one further year of preregistration training as

³ *British Medical Journal*, 1965, 1, 306.

resident house-physician or house-surgeon. A move to increase this to two years has not found favour in New Zealand.

So far as the preregistration year goes the University of Auckland is urging the New Zealand Medical Council (which is the body concerned with registration) to exercise a much stricter control over the assessment of the preregistration graduate. In the past all that has been required has been a certificate of experience rather than competence given by the appropriate medical superintendent. In addition, there has been no adequate teaching in some of the hospitals. The University of Auckland is suggesting that a training programme be laid down for this year also. This should be under the supervision of the university concerned, and the Medical Council should require an assessment by the university of the actual performance of the graduate before granting him registration.

The postgraduate aspects of medicine have not been forgotten by the Auckland committee. Throughout its report it has stressed the integration of medical studies throughout the doctor's life, beginning with his B.Sc. in human biology. All the departments of the medical school are being planned on the assumption of strong postgraduate activities, and indeed Auckland has led New Zealand for some years in this field. The general practitioners, through their college, are urging the University of Auckland to set up a Diploma of General Practice as a postgraduate subject comparable with, but a little more elaborate than, the already existing Diploma in Obstetrics granted by the University of Auckland postgraduate school.

Association of Physicians of East Africa

The annual conference of the Association of Physicians of East Africa was held in Nairobi on 23–26 June. The conference was opened by the Hon. J. D. OTIENDE, Minister for Health and Housing to the Kenya Government. In the absence of the president, Dr. D. G. T. HICKS, an address on postgraduate medical education and qualifications in East Africa was given by the vice-president, Dr. A. G. SHAPER.

Haematology and Heart Diseases

Professor A. S. DOUGLAS (Kenya/Glasgow) demonstrated by serial angiographic studies the technique of thrombus formation in Chandler's tube and described the effects of anticoagulant therapy and streptokinase on platelet aggregation during thrombus formation. He showed that streptokinase disrupted the fibrin tail and the platelet head of the Chandler's thrombus when the thrombus was placed in an artificial circulation.

A study of clot lysis, clot strength, and platelet adhesiveness in African and Asian men aged 40–60 years was reported by Dr. A. G. SHAPER (Uganda). The African subjects lysed their *in vitro* clots very rapidly compared with the Asian subjects, who had far stronger clots and far longer lysis times. It was suggested that the fibrinolytic mechanism might be of importance in explaining the difference in occurrence rates of thromboembolic phenomena in these two groups.

Venom from the puff adder causes a haemorrhagic state *in vivo*, and Dr. C. FORBES and his colleagues (Kenya/Glasgow) showed that *in vitro* the venom inhibited

blood coagulation and interfered with thrombus formation in a Chandler's tube. The theoretical potential of this material in the management of thromboembolic disease was discussed.

Anaemia of pregnancy is the greatest cause of non-obstetric maternal mortality in Kampala, and Dr. P. J. S. HAMILTON and others showed that a small group of these patients had an acute haemolytic anaemia associated with splenomegaly and with lymphocytic infiltrates of the hepatic sinusoids. It was suggested that this condition might be an abnormal immune response to malaria exacerbated by pregnancy, and the group advocated prophylactic antimalarial therapy in cases of splenomegaly. Dr. J. R. HARRIES (Kenya) described haemodynamic studies carried out on subjects with large spleens, and the effects of injecting α -adrenergic blocking agents into the spleen.

A detailed study of jaundice in the African neonate was presented by Dr. A. A. KHAN (Kenya), and the high proportion of ABO haemolytic disease in this group was stressed. Exchange transfusion was frequently indicated in this disorder. Dr. R. FOSTER (Kenya) reported a follow-up of cases of obscure heart failure in Mombasa. His results suggested that hypertension was a common cause of unexplained heart failure, even though the subjects were never hypertensive in hospital.

Bilharzia

Snail population studies in widely separated areas of East Africa show seasonal trends in

density and breeding of snails and in transmission patterns of bilharziasis. Mr. G. WEBBE (Tanzania) considered that these trends could be used as a basis for the timing of measures directed towards the control of transmission, but emphasized that data from one area should not be extrapolated directly to other areas. Treatment of infected persons which resulted in a reduction of egg load should be regarded as a complement to measures directed against snail hosts. Dr. P. JORDAN (Tanzania) discussed the control of transmission of *Schistosoma haematobium* by chemotherapy; the evidence suggested that teenagers were largely responsible for maintaining transmission. The beneficial effects to the individual of suppressive therapy and "failed" curative treatment were noted. A clinical survey of *Schistosoma mansoni* infections in hospitalized subjects in Uganda by Dr. J. R. BILLINGHURST suggested that as seen in Kampala this was a relatively mild disease.

Dr. D. FORSYTH (Tanzania) presented material which indicated that the early clinical manifestations of *S. haematobium* infection were insignificant and that the urological complications, which might be very severe, developed insidiously. Dr. P. JORDAN reported in the use of Ciba 32, 644-Ba in the treatment of *S. mansoni*, and noted that the peculiar mental states he had observed had also been encountered in other studies with this drug. Dr. D. FORSYTH considered that previous methods of treating urinary bilharziasis had been based on fundamental misconceptions, and he outlined a more rational approach to effective therapy. He stressed that any of the appropriate drugs